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PREFERRED PROVIDER ORGANIZATION (PPO) ADMINISTRATIVE AGREEMENT

By and Between

CITY OF HOUSTON
(called the Plan Sponsor in this Agreement)

and

BLUE CROSS AND BLUE SHIELD OF TEXAS,
a Division of Health Care Service Corporation, a Mutual Legal Reserve Company
(called the Administrator in this Agreement)

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PREFERRED PROVIDER ORGANIZATION (PPO) ADMINISTRATIVE AGREEMENT

This **PREFERRED PROVIDER ORGANIZATION (PPO) ADMINISTRATIVE AGREEMENT** (the "Agreement") is entered into by and among **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (the "Administrator"), a corporation organized under the laws of the State of Texas with its principal Texas office at 901 South Central Expressway, Richardson, Texas 75080, and the **CITY OF HOUSTON** (the "Plan Sponsor"), a municipal corporation and home-rule city of the State of Texas acting by and through its governing body, the City Council, and with its principal office at 901 Bagby Street, Houston, Texas.

WHEREAS, the Plan Sponsor is facilitating the establishment of an employee health benefit plan for certain of its employees and their dependents (the "Plan"), that is described in the Plan Document annexed to this Agreement as Exhibit A; and

WHEREAS, the Administrator hereby agrees to furnish certain limited administrative services to the Plan Sponsor with respect to the Plan, as specified in this Agreement; and

NOW THEREFORE, in consideration of the mutual undertakings contained in this Agreement, and intending to be legally bound hereby, the Plan Sponsor and the Administrator agree as follows:

Article I

Definitions

For purposes of this Agreement, the following definitions shall apply:

"Administrator" means **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company**, in its capacity as provider of the Preferred Provider Organization Administrative services under this Agreement, who undertakes to act only as a contractor, and not as an insurer, for the Plan Sponsor in providing services as specified in this Agreement for the administration of the Plan.

"Charges" means the Fee-for-Service Medical Charges, Fixed Administrative Charges, and Charges for Additional Services described in Exhibit B to this Agreement.

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985.

"Covered Services" means Medically Necessary health care services and supplies, specified as covered in the Schedule of Benefits, that are received by Participants in accordance with the terms and procedures of the Plan.

"Fee-for-Service Medical Charges" means the fee-for-service charges to be paid by the Plan Sponsor for Covered Services, as described in Exhibit B.

"Fixed Administrative Charge" means the per Subscriber per month fee to be paid by the Plan Sponsor to the Administrator, as described in Exhibit B.

"Health Care Provider" means a physician, hospital, pharmacy or other person or facility licensed or otherwise duly authorized to provide health care services under the laws of the jurisdiction in which such provider or facility renders such services. The term "Health Care Provider" includes, but is not limited to, In-Network Health Care Providers.

"In-Network Health Care Provider" means a Health Care Provider under contract with the Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in the BlueChoice PPO provider network.

"Legal Claim" means any lawsuit, demand for arbitration or other legal proceeding, or written threat to commence such a legal proceeding, arising out of or in relation to the Plan.

"Network" means the In-Network Health Care Providers as listed in the BlueChoice provider directory or as found by accessing Administrator's Provider Finder at www.bcbstx.com..

"Normal Business Hours" means Monday through Friday 7:30 a.m. to 6:00 p.m.

"Participant" means a person who is enrolled in the Plan and entitled to receive benefits in accordance with its terms.

"Plan" means the employee health benefit plan facilitated or established by the Plan Sponsor and administered by the Administrator pursuant to this Agreement.

"Plan Document" means the document, annexed as Exhibit A, describing the benefits available to Participants under the Plan and terms under which such benefits shall be available to Participants.

"Plan Sponsor" means the City of Houston.

"Quality Management" means the measurement and evaluation of the quality of care provided to Participants by In-Network Health Care Providers and the implementation of steps to improve such quality.

"Service Area" means a geographic area identified in Exhibit C to this Agreement. The area(s) shown are those in which a Network of preferred providers is offered, available, and is used to determine eligibility for managed health care benefits under the Plan.

"Subscriber" means a "Subscriber" as defined in the Plan Document.

Article II

Representations

2.1 The Administrator represents:

(a) That it has Health Care Providers under contract who comprise the Network;

(b) That it provides certain administrative systems to support the Network's provision of Covered Services;

(c) That it has established the administrative systems and procedures necessary for administering the Plan in accordance with this Agreement;

(d) That the Administrator is a corporation duly organized, validly existing and in good standing under the laws of the State of Illinois, and has all requisite corporate power and authority to own, lease and operate its properties and to carry on its business as now being conducted;

(e) That the execution, delivery and performance of this Agreement by the Administrator have been duly and validly authorized by all necessary corporate action on the part of the Administrator, and this Agreement is a valid and binding obligation of the Administrator. Neither the execution and delivery of this Agreement nor compliance by the Administrator with any of the provisions hereof will (i) conflict with or result in a breach of any provision of its Articles of Incorporation or Bylaws, (ii) result in a material default or give rise to any right of termination, cancellation or acceleration under any of the terms, conditions or provisions of any note, mortgage, indenture, license, agreement or any interests or obligations to which the Administrator is bound or (iii) violate any order, writ, injunction, decree, statute, rule or regulation applicable to the Administrator or any of its property or assets. No consent or approval by any governmental authority is required in connection with the execution, delivery or performance by the Administrator of this Agreement; and

(f) That the Administrator has made or holds such registration(s), license(s) or certification(s) required by law to perform the services required of it under this Agreement, and such registration(s), license(s) or certification(s) have never been denied, suspended, revoked, terminated, voluntarily relinquished or otherwise restricted in any way.

2.2 The Plan Sponsor represents:

(a) That it retains the Administrator for the limited purpose of providing administrative services for the Plan and performing the other duties, responsibilities and obligations of Administrator set forth in this Agreement; and

(b) That it has established the Plan in accordance with applicable legal requirements and that the terms of the Plan are as set forth in the Plan Document.

Article III

Effective Date - Agreement Term - Termination

3.1 **Effective Date**: This Agreement shall take effect on May 1, 2006 (the "Effective Date.

3.2 **Term**: The term of this Agreement is for the period beginning on the Effective Date and ending at midnight on April 30, 2009 (the "Term"). The Term may be extended for two additional one year periods through April 30, 2011, as provided in Section 3.8, below.

3.3 **Termination for Cause**: This Agreement shall terminate for cause in accordance with subparagraphs (a) through (d) below, with any termination in accordance with subparagraphs (a) through (d) below being deemed "for cause":

(a) Sixty (60) days after delivery of written notice by either party to the other party pursuant to Article X, Section 10.15 of this Agreement, upon the material failure of the other party to comply with this Agreement, unless such failure described in the notice is cured within said sixty (60) days. However, if the failure to comply is the Plan Sponsor's failure to pay Charges, this Agreement shall terminate thirty (30) days after written notice to the Plan Sponsor of such non-payment, and unless full payment is made within the thirty (30) days, coverage under the Plan shall be canceled retroactive to the last date for which the Charges were paid.

(b) Fifteen (15) days after delivery of written notice by either party to the other party pursuant to Article X, Section 10.15 of this Agreement, upon the material failure of the other party to comply with applicable statutory or regulatory requirements, unless such failure described in the notice is cured within said fifteen (15) days.

(c) Sixty (60) days after delivery of written notice by either party to the other party pursuant to Article X, Section 10.15 of this Agreement, upon gross negligence, fraud or embezzlement on the part of the other party, as described in the notice.

(d) Sixty (60) days after delivery of written notice by either party to the other party pursuant to Article X, Section 10.15 of this Agreement, upon the bankruptcy, insolvency, or assignment for the benefit of creditors of the other party, to the extent permitted by law, as described in the notice.

3.4 **Termination by Mutual Consent**: The Plan Sponsor and the Administrator may terminate this Agreement by mutual consent at any time, without the consent of any Participant or any other third party.

3.5 **Discontinuance of Plan**: This Agreement shall terminate automatically if the Plan is discontinued in accordance with its terms or by operation of law.

3.6 **Material Modification of the Plan**: In the event that the Plan Sponsor desires to modify the Plan in any manner that materially alters the Administrator's obligations, compensation or risk under this Agreement, the Plan Sponsor shall give the Administrator at least sixty (60) days' written notice describing the proposed modification. During this notice period, the parties shall negotiate in good faith toward a mutually agreeable accommodation of the proposed modification. If, within the sixty (60) days, the parties are unable to agree and the proposed modification has not been withdrawn by Plan Sponsor, this Agreement shall terminate at the end of an additional sixty (60) days, unless the parties otherwise agree in writing.

3.7 **Runoff of Claims**:

(a) Upon the termination or expiration of this Agreement, the Administrator and the Plan Sponsor shall have the following duties and responsibilities:

(1) The Administrator shall process and pay, in a timely manner, all benefit claims incurred by or on behalf of Participants on or before the termination or expiration date, that are received by the Administrator within one year after the termination or expiration date. The Administrator's fee for processing these claims is included in the Fixed Administrative Charge.

(2) The Administrator shall send to the Plan Sponsor for processing claims that are incurred by or on behalf of a Participant on or before the termination or expiration date and received by the Administrator more than one year after the termination or expiration date.

(3) Plan Sponsor shall pay to Administrator all Fixed Administrative Charges through the end of the month during which the termination or expiration date occurs.

(4) The Administrator and the Plan Sponsor shall reasonably cooperate with each other to effect an orderly transition between the Administrator and its successor.

(b) Termination or expiration of this Agreement will not affect the rights or obligations of either party arising out of this Agreement during the period when this Agreement was in effect.

(c) The following provisions shall survive the expiration or other termination of this Agreement regardless of the cause of such termination: 5.9, 5.10, 5.11, 6.1.

3.8 **Term Extension**: The Plan Sponsor's Human Resources Director may cause the term of this Agreement to be extended for two additional one year periods from May 1, 2009, through April 30, 20011, by delivering a written notice of extension to the Administrator on or before November 1, 2008 or date mutually agreed upon by the parties hereto. It is agreed that the foregoing extension option may be exercised at the sole option of the Plan Sponsor acting by and through its Human Resources Director and shall not be subject to refusal by the Administrator.

Article IV

Duties and Responsibilities of the Plan Sponsor

4.1 The Plan Sponsor hereby contracts with and appoints the Administrator to provide administrative services and perform the other duties, responsibilities and obligations of Administrator set forth in this Agreement. The responsibilities of the Administrator shall be limited to those expressly set forth in this Agreement or as mutually agreed to in writing by the Plan Sponsor and the Administrator. The Plan Sponsor shall be responsible and liable for payment of Fixed Administrative Charges and Fee-for-Service Medical Charges to the Administrator. However, nothing in this Agreement shall be construed to create an obligation on behalf of the Plan Sponsor or the Administrator as a provider of insurance. Furthermore, it is understood between the parties that the Plan being administered hereunder does not constitute a policy of insurance and is not subject to regulation as an insurance product under Texas law.

4.2 The Plan Sponsor agrees to pay all Charges as specified in Exhibit B to this Agreement and to transfer payment to Administrator in accordance with Addendum B of this Agreement.

4.3 The Plan Sponsor shall be responsible for determining the eligibility of Participants to participate in the Plan and shall provide the Administrator with eligibility information on a timely basis, in a format to be mutually agreed upon. The Plan Sponsor shall also be responsible for giving all required notices to Participants, including any applicable notices required under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); Chapter 174 of the Texas Local Government Code; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If a Participant ceases to be enrolled under the Plan, but continues to receive benefits because of the Plan Sponsor's failure to notify the Administrator of such individual's termination as a Participant, the Plan Sponsor shall be required to pay all Charges with respect to such individual, up until the point when the Administrator is notified of the termination; however, this obligation shall not affect Plan Sponsor's rights to recover costs from the individual who erroneously received the benefit. Claims associated with transitional conditions set forth in Article IX shall be considered outside of claims targets and stop loss provisions.

4.4 The Plan Sponsor's Human Resources Director ("the Director") will designate to the Administrator the names of individuals, together with the scope of their authority, authorized to act for and bind the Plan Sponsor in connection with this Agreement. Without limiting the authority of the Director or his designees as set forth in this Section 4.4, the Plan Sponsor's City Attorney is authorized to enforce the City's rights under this Agreement.

4.5 The Plan Sponsor shall advise the Administrator on a timely basis of any changes to the Plan, including but not limited to, benefit and administrative changes. The Plan Sponsor's right to make changes in the Plan shall be subject to Section 3.6 above.

4.6 If the Plan Sponsor or the Administrator becomes aware of any written Legal Claims or threats of a Legal Claim from a Participant, or any non-routine complaint to or from any state or federal regulatory authority arising out of or in relation to the Plan, the Plan Sponsor or Administrator shall promptly notify the other party. The Plan Sponsor and the Administrator will cooperate with each other in responding to any such complaint.

4.7 If the Plan Sponsor or Administrator becomes aware of any Legal Claim, it shall promptly notify the other party in writing. The Administrator shall not be liable or responsible for any Legal Claim or any payment thereon, including any cost of defense judgment or settlement, except that:

(i) the Administrator shall indemnify the Plan Sponsor as provided in Section 5.11 of this Agreement; and

(ii) if the Administrator elects to be represented by legal counsel other than the legal counsel representing the Plan Sponsor, the Administrator shall pay the reasonable fees and expenses of such counsel.

The Plan Sponsor and the Administrator will cooperate with each other in the defense of any Legal Claim.

4.8 Plan Sponsor may, at its request, review the Administrator's final disposition of any appeal concerning interpretation of the Plan. Subject to compliance with applicable statutes, regulations, or laws, any such review shall be conducted with due regard for the confidentiality of the Participant's medical information. In the event of a difference between Plan Sponsor and Administrator, the Plan Sponsor's determination shall be final and binding, subject to compliance with applicable statutes, regulations, and laws as set forth in Section 6.1 below.

4.9 The Plan Sponsor shall make reasonable, good faith efforts to perform all its duties, responsibilities and obligations hereunder so as to ensure that none of their actions cause the Plan to be administered in contravention of any applicable statute or regulation.

4.10 The Administrator, in performing its duties as outlined in this Agreement, may from time to time require information and or records from the Plan Sponsor, which may include but are not limited to, eligibility, payroll and other information. Plan Sponsor agrees to give the Administrator access to such information, as agreed upon by both parties, on reasonable notice during Normal Business Hours.

4.11 The Administrator and the Plan Sponsor may use each other's names from time to time upon mutual written consent.

Article V

Duties and Responsibilities of the Administrator

5.1 The Administrator is empowered to act in connection with the Plan only as stated expressly in this Agreement or as mutually agreed to in writing by the Plan Sponsor and the Administrator.

5.2 The Administrator, on behalf of the Plan Sponsor, shall administer the Plan, process and pay claims for Covered Services and provide benefits in accordance with the terms of the Plan and this Agreement. Administrator shall administer the medical claims processing and customer service functions from Administrator's Houston office. Administrator may continue to delegate processing of claims for certain other benefits to the delegated entities that administer those benefits. Administrator may centralize certain functions where the economies of scale or other efficiencies will provide advantages to the Plan Sponsor or Participants, which may include paying claims in another centralized claims paying location. These may include eligibility processing (membership) and distribution of identification cards and fulfillment information to Participants, imaging of documentation, and similar functions. Administrator shall continue to maintain on-site customer service representation at a location to be designated by the Plan Sponsor. Claims processing shall include coordination of benefits with other health plans. The Administrator shall perform the assigned tasks, duties, responsibilities and actions stated for the "Administrator" in the Plan, such tasks, duties, responsibilities and actions are hereby incorporated herein by reference and applied to the Administrator, and the Administrator under the Plan shall mean and refer to the Administrator herein for the Term of this Agreement.

5.3 The Administrator represents and warrants that it shall maintain the Network and make it available to Participants within the Service Area. The Administrator represents and warrants that it will maintain the Network so that In-Network Health Care Providers of various specialties and types are available and accessible. In addition, with respect to In-Network Health Care Providers, the Administrator represents and warrants that it will (a) make a good faith effort to ensure that providers are available for providing urgent care, and (b) recredential physicians no less than every three years.

Administrator represents that the Network is and has been stable in Houston and throughout Texas. It is Administrator's intention to maintain that Network stability, which will include continuing to provide convenient Participant access to a broad Network of primary care and specialty care physicians, as well as hospitals and other ancillaries, in all areas of the Greater Houston community and in the Texas Medical Center. This commitment also applies to all other metropolitan and rural areas across the state of Texas and is consistent with the commitment of other Blue Cross plans outside of Texas where City of Houston Participants may reside.

5.4 The Administrator, on behalf of the Plan Sponsor, shall provide utilization review and Quality Management programs in connection with the Plan as follows:

(a) Utilization Review: A hospital utilization review procedure that includes:

(1) Pre-admission review and certification within the time frames established by applicable law and regulation;

(2) Concurrent review, length of stay certification and discharge planning;

(3) Retrospective review; and

(4) Case management of long stay and catastrophic cases.

Administrator will maintain a Participant to utilization review staff ratio in accordance with industry standards The utilization review program shall also examine the cost and economic appropriateness of the utilization of health care resources, so as to identify variances from previously established and professionally recognized norms and to attempt to correct variances where appropriate.

The Administrator shall utilize such services as it shall reasonably deem appropriate to conduct and coordinate the tasks listed above, including a medical director, one or more physician advisors and registered nurses. The Administrator shall take no action to relieve the patient and the patient's physician from responsibility for decisions regarding medical necessity, hospital admission and other decisions of medical care. The Administrator's utilization review program shall be designed to make recommendations regarding whether a service provided or to be provided is medically necessary and at an appropriate level of care in a timely and cost-effective manner and is covered under the Plan. Administrator will also identify needs for the

development of education materials for Participants and In-Network Health Care Providers which will promote the appropriate use of medical services

(b) Quality Management: Maintain a Quality Management program designed to continually examine the quality of medical care provided to Participants, study physician and other health care provider patterns and utilization of health services to identify physicians and other health care providers who practice quality, cost effective medicine, and generally evaluate and enhance the extent to which medical services are being provided in an appropriate manner.

(c) All benefit coverage issues shall be investigated, analyzed and resolved by the Administrator in the same manner employed by the Administrator in administering its fully insured preferred provider organization plans or requires by applicable statute, regulation or law.

5.5 The Administrator shall provide for access by Participants to its Participant service personnel for assistance with benefit inquiries, claims status and selection of In-Network Health Care Providers. The Administrator's Participant service personnel shall be available by telephone during Normal Business Hours. The Administrator shall comply with the service performance standards set forth in Exhibit E.

5.6 The Administrator shall notify any Participant whose request for Plan benefits is denied of the reasons for the denial (by means of an explanation of benefits or such other form of communication as may be appropriate) and the Participant's right to have the denial reviewed under the Plan's standard appeal procedures. The notification and review shall be in a manner agreed upon by the Plan Sponsor and the Administrator and designed to satisfy all applicable legal requirements.

5.7 The Administrator shall assist the Plan Sponsor in connection with the design and development of the Plan, both initially and in connection with subsequent revisions. Such assistance shall include, at the request of the Plan Sponsor: underwriting and actuarial services; estimates of initial Plan costs; cost projections of proposed Plan revisions; and advice and assistance in the preparation of Plan descriptive materials.

5.8 The Administrator shall be responsible for the following enrollment, ongoing communication, education and wellness services.

(a) During group enrollment periods, the Administrator shall provide services for Group employees including the design and distribution of enrollment packets; attendance at enrollment meetings to provide information and respond to questions; upon request, help provide content for a customized video tape presentation to be prepared by Plan Sponsor, benefit summaries, visual display and graphics; and orientation for benefit coordinators to describe benefit changes. The cost of these materials is included in the Fixed Administrative Charge.

(b) On an ongoing basis, the Administrator will provide Participant identification cards, claim forms, benefit summaries, newsletters, brochures, an administration manual for benefit coordinators, and similar materials. At the reasonable request of the Plan Sponsor, the Administrator shall provide Spanish translations of these materials. The cost of these materials is included in the Fixed Administrative Charge.

(c) The Administrator will, upon request of the Plan Sponsor, participate in the City of Houston health fair to promote wellness. The Administrator will also send informed employees of Administrator to selected sites to provide information relating to the Plan to interested employees. Administrator will make available to Participants any applicable discount or promotional program that complies with Texas law and regulation that Administrator makes available to similarly situated members of comparable health benefits plans for which Administrator provides administrative services only. The cost of these services is included in the Fixed Administration Charge.

5.9 The Administrator will furnish to the Plan Sponsor such information as is reasonably available to the Administrator, which may be needed by the Plan Sponsor to satisfy any regulatory reporting requirements.

5.10 During the term of this Agreement, including any extensions thereof, the Administrator shall have in effect liability insurance coverage of such types and in such amounts as are customary for a business of its size and nature, including professional liability insurance in excess of $10 million per claim, $10 million aggregate. The issuers of such policies shall, to the best of the Administrator's knowledge, be responsible and reputable, and shall have financial capability consistent with the risks covered. The professional liability policy shall provide for at least thirty (30) days' notice of cancellation or non-renewal; in the event of cancellation or non-renewal, the Administrator shall promptly notify the Plan Sponsor. In addition, the Administrator shall give thirty (30) days' notice of its intention to materially modify the professional liability policy. With respect to the Administrator's policy of comprehensive general liability insurance, the Administrator shall have the Plan Sponsor added as an additional insured. At the request of the Plan Sponsor, the Administrator shall provide to the Plan Sponsor certificates of insurance with respect to such policies.

5.11 **IN PERFORMING UNDER THIS AGREEMENT, THE ADMINISTRATOR SHALL USE ORDINARY AND REASONABLE CARE, TO THE SAME DEGREE AS REQUIRED BY LAW OR THAT A PRUDENT INSURANCE COMPANY WOULD USE IN PAYING CLAIMS FROM ITS OWN FUNDS, WHICHEVER IS GREATER. HOWEVER:**

(A) **THE ADMINISTRATOR SHALL INDEMNIFY AND HOLD THE PLAN SPONSOR HARMLESS FROM AND AGAINST ALL CLAIMS, DEMANDS, COSTS, DAMAGES, JUDGMENTS, REASONABLE ATTORNEYS' FEES, EXPENSES AND LIABILITIES OF ANY KIND OR NATURE (COLLECTIVELY, "LIABILITIES"), WHETHER IN EQUITY OR AT LAW, ARISING FROM CLAIMS OR DEMANDS MADE BY PARTICIPANTS OR OTHER THIRD PARTIES AGAINST THE PLAN SPONSOR, THAT OCCUR AS THE RESULT OF:**

(i) **THE ADMINISTRATOR'S FAILURE TO ACT IN GOOD FAITH WITH RESPECT TO THE ADMINISTRATION OF CLAIMS UNDER THE PLAN; OR**

(ii) **THE NEGLIGENT OR INTENTIONALLY WRONGFUL ACTS OR OMISSIONS OF THE ADMINISTRATOR OR ITS EMPLOYEES OR AGENTS WITH RESPECT TO ITS PERFORMANCE OF ITS RESPONSIBILITIES UNDER THIS AGREEMENT.**

(B) **IN ADDITION, THE ADMINISTRATOR SHALL INDEMNIFY AND HOLD THE PLAN SPONSOR HARMLESS, TO THE SAME EXTENT AS SET FORTH IN 5.11(A) ABOVE, AS FOLLOWS:**

(I) **IN A LAWSUIT IN WHICH BOTH THE ADMINISTRATOR AND THE PLAN SPONSOR ARE PARTIES, WHERE THE PLAN SPONSOR IS ADJUDICATED BY A TRIAL COURT OF COMPETENT JURISDICTION NOT TO BE LIABLE TO ANY PARTY, THE ADMINISTRATOR SHALL REIMBURSE THE PLAN SPONSOR FOR ITS REASONABLE ATTORNEYS' FEES AND OUT-OF-POCKET EXPENSES IN DEFENDING SUCH LAWSUIT, EVEN IF THE ADMINISTRATOR IS ALSO ADJUDICATED NOT TO BE LIABLE TO ANY PARTY.**

(II) **IN A LAWSUIT IN WHICH BOTH THE ADMINISTRATOR AND THE PLAN SPONSOR ARE PARTIES OR AGAINST THE PLAN SPONSOR ONLY, WHERE THE SOLE ACTIONABLE THEORY OF LIABILITY AGAINST THE PLAN SPONSOR IS THAT THE ADMINISTRATOR FAILED TO PROVIDE THE QUALITY, TYPE, OR MANNER OF SERVICE TO PARTICIPANTS THAT IT REPRESENTED IT WOULD PROVIDE, AND THAT THE PLAN SPONSOR IS LIABLE BECAUSE IT NEGLIGENTLY SELECTED THE ADMINISTRATOR TO ADMINISTER THE PLAN AND/OR FAILED ADEQUATELY TO SUPERVISE THE ADMINISTRATOR IN THE ADMINISTRATION OF THE PLAN, THE ADMINISTRATOR SHALL ASSUME THE PLAN SPONSOR'S DEFENSE AND PAY ALL LIABILITIES OF THE PLAN SPONSOR RESULTING FROM SUCH LAWSUIT. IN SUCH A CASE, THE ADMINISTRATOR SHALL, AFTER CONSULTATION WITH THE PLAN SPONSOR, SELECT OUTSIDE COUNSEL**

TO REPRESENT THE PLAN SPONSOR (THAT MAY BE THE SAME AS THE ADMINISTRATOR'S OUTSIDE COUNSEL, SO LONG AS A CONFLICT OF INTEREST BETWEEN THE ADMINISTRATOR AND THE PLAN SPONSOR DOES NOT PRECLUDE REPRESENTATION BY THE SAME COUNSEL). NOTWITHSTANDING THE ADMINISTRATOR'S ASSUMPTION OF THE PLAN SPONSOR'S DEFENSE AS DESCRIBED ABOVE, THE ADMINISTRATOR SHALL, AT THE PLAN SPONSOR'S REQUEST, KEEP THE PLAN SPONSOR REASONABLY INFORMED REGARDING THE STATUS OF THE LAWSUIT.

(III) IN A LAWSUIT AGAINST THE ADMINISTRATOR AND THE PLAN SPONSOR OR AGAINST THE PLAN SPONSOR ONLY ASSERTING MULTIPLE THEORIES OF LIABILITY, OF WHICH ONE IS THE THEORY OF LIABILITY DESCRIBED IN SUBPARAGRAPH (II) ABOVE, THE ADMINISTRATOR SHALL, AT THE CONCLUSION OF THE LAWSUIT, REIMBURSE THE PLAN SPONSOR FOR THE SHARE OF THE PLAN SPONSOR'S LIABILITIES THAT IS ATTRIBUTABLE TO THAT SPECIFIC THEORY OF LIABILITY.

(C) NOTWITHSTANDING THE FOREGOING, THE ADMINISTRATOR'S OBLIGATION TO INDEMNIFY SHALL NOT EXTEND TO ANY OF THE FOLLOWING:

(i) LIABILITIES ARISING FROM ACTS OR OMISSIONS OF THE PLAN SPONSOR, ITS OFFICERS, DIRECTORS OR EMPLOYEES, EXCEPT THOSE SET OUT IN SUBPARAGRAPHS B(II) AND (III) ABOVE;

(ii) ANY SETTLEMENT TO WHICH THE ADMINISTRATOR HAS NOT GIVEN ITS PRIOR CONSENT IN WRITING, PROVIDED THAT SUCH CONSENT SHALL NOT BE UNREASONABLY DELAYED, WITHHELD OR QUALIFIED; OR

(iii) THE ACTUAL COST OF BENEFITS TO WHICH PARTICIPANTS ARE ENTITLED UNDER THE PLAN.

NOTHING IN THIS AGREEMENT SHALL BE DEEMED TO IMPOSE ON EITHER THE ADMINISTRATOR OR THE PLAN SPONSOR ANY LIABILITIES ARISING FROM ACTS OR OMISSIONS OF HEALTH CARE PROVIDERS WHO PROVIDE COVERED SERVICES TO PARTICIPANTS.

5.12 The Administrator shall require that In-Network Health Care Providers maintain during the Term of this Agreement available medical malpractice liability insurance protection in the minimum amount required by law, but at no time less than two hundred thousand dollars ($200,000) per claim, six hundred thousand dollars ($600,000) annual aggregate.

5.13 Based on timely notification of changes in benefits and timely notification of eligibility changes, if, through error on the Administrator's part, the Administrator pays any Participant less or more than the amount to which he is entitled under the Plan, or makes any payment to a person who is not entitled to receive it, the Administrator shall reimburse the Plan Sponsor for the overpayment.

5.14 The Administrator shall provide claims and payment records and data and shall provide other collections-related support to the Plan Sponsor as may be reasonably necessary for pursuit of collections by the Plan Sponsor's City Attorney or such other counsel as may be designated by the City Attorney to seek nonjudicial or judicial recovery of overpayments.

5.15 The Administrator, on behalf of the Plan Sponsor, is assigned the right to seek reimbursement from responsible third parties, with recoveries subject to the fees indicated in Exhibit B to this Agreement. The indicated fees are based on the net recovery after attorney's fees, if any, have been paid. Upon reimbursement, and after all applicable fees have been paid, the Administrator shall pay to the Plan Sponsor the remaining reimbursement amount.

Administrator's comprehensive recovery program is administered by a dedicated internal department, the Corporate Reimbursement/ Subrogation Department (the "Department"). The Department shall maintain a

fully automated recovery process from the time a claim is selected for investigation until the time a case settles. The process will identify potential other party liability claims based on the diagnostic and treatment codes. Claims are then associated into cases based on similar claim data. Once a case, whether it is comprised of a single claim or an aggregate of claims, has reached the specified dollar threshold of $500.00, the Department shall conduct an investigation. The Department's investigation shall include no less than three (3) Subscriber contact attempts to gain the information needed to ascertain liability and potential recovery sources. If other party liability exists, the Department shall aggressively pursue the case towards settlement negotiations with the authorized representatives of the responsible parties.

5.16 The Administrator shall provide to the Plan Sponsor the reports and data analyses regarding Plan operations listed in Exhibit F. This list may be modified from time to time by agreement between the Administrator and Plan Sponsor.

5.17 In the event that a Participant's right to coverage under the Plan terminates (including termination of the Participant's right to continued health coverage under federal or state law) while this Agreement is in effect, the Administrator shall make available to such Participant any individual conversion plan that would be available to a similarly situated HMO member for which such Participant then qualifies.

Article VI

Relationship of Parties

6.1 In performing the services described in this Agreement, the Administrator shall not be designated or deemed the fiduciary with respect to the Plan or a fiduciary with respect to review of claim denials under the Plan. The Plan Sponsor agrees to accept the Administrator's decisions, made pursuant to the provisions of the Plan that are to be administered by the Administrator, in accordance with applicable statutes, regulations or laws, as to the amounts of Plan benefits for which the Plan Sponsor must pay. In performing its services hereunder, Administrator is acting as an independent contractor. The Plan Sponsor shall not have any right to direct or control the Administrator's acts, decisions, judgment, assignment of personnel or other actions in the performance of its services hereunder. The Administrator retains the right to provide administrative services to parties other than the Plan Sponsor. In no event shall this Agreement be construed to create a partnership, joint venture or similar relationship or an employer-employee relationship. The Administrator shall be liable for its own debts, obligations, acts and omissions, including the payment of all required withholding, social security and other taxes and benefits.

Article VII

Transfer Payments

7.1 The parties' Transfer Payment arrangements in connection with the administration of the Plan shall be as outlined in Addendum B.

Article VIII

Administrative Charges

8.1 The Charges to be paid by the Plan Sponsor pursuant to this Agreement shall be as described in Exhibit B hereto. The overall rates and guarantees agreed to by the Administrator with respect to the Plan are set forth in Exhibit G hereto.

Article IX
Transition

Intentionally omitted.

Article IX-A

Administration of Retirees' Hospitalization and Medical-Surgical Program

9A.1 This article relates to the administration by the Administrator of the Retirees' Hospitalization and Medical-Surgical Program ("the Retiree Plan").

9A.2 Effective May 1, 2006, the Administrator shall continue to provide administrative services for the Retirees' Plan.

9A.3 It is understood that the Retiree Plan is a closed benefits program with a very limited enrollment, that provides coverage as stated in Exhibit A-1. Accordingly, the Retiree Plan and its administration will differ substantially from the Plan that is otherwise administered under this Agreement. Except as the aforesaid differences may require, the Retiree Plan shall be subject to administration under the same terms and provisions as are otherwise set out in this Agreement. The Administrator and the Plan Sponsor's Human Resources Director may establish any required procedures for the administration of the Retiree Plan.

9A.4 Without limitation of Section 9A.3, it is understood that:

(a) Utilization review shall be provided only to the extent contemplated in the Retiree Plan, which is generally limited to precertification and concurrent review of hospitalizations.

(b) The Plan Sponsor shall pay a monthly Administration fee for Retiree Plan Subscriber as set forth in Exhibit B, Section 1(b) of this Agreement.

(c) Payments for claims under the Retiree Plan shall be payable in accordance with the same banking arrangements and other procedures that apply to the payment of Fee-for-Service Medical Charges under the Plan.

(d) The stop loss provisions of this Agreement do not extend to the Retiree Plan.

(e) The Administrator shall maintain a separate accounting of all expenditures by the Plan Sponsor for the Retiree Plan.

Article X

Other

10.1 During the Term of this Agreement, the Administrator shall provide stop loss insurance for or on behalf of the Plan in the form annexed hereto as Exhibit H. Notwithstanding any provisions in the stop loss insurance to the contrary, the Administrator shall provide the stop loss coverage at rates not to exceed those specified in Exhibit G. The parties understand that the stop loss insurance shall be paid exclusively from Subscriber's contributions. The specimen stop loss insurance schedule of coverage included in Exhibit H is based upon the following assumptions:

(a) 110% attachment point

(b) $300,000 individual attachment point

(c) Maximum $2,000,000 coverage above the attachment point.

10.2 The Administrator shall comply with the provisions of the Plan Sponsor's Equal Opportunity Ordinance as set out in Exhibit I.

10.3 The Administrator agrees to use its best efforts to carry out the Plan Sponsor's policy with regard to minority and women business enterprises as set out in Exhibit J.

10.4 The Administrator agrees to the terms and conditions set out in Exhibit K regarding the Plan Sponsor's allocation and appropriation of funds to pay the Administrator under this Agreement.

10.5 The Administrator shall abide by the Plan Sponsor's policy against the use of illegal drugs, substance abuse and alcohol abuse in the workplace. The manufacture, distribution, dispensation, possession sale or use of illegal drugs by the Administrator's employees while engaged in activities related to the Plan is prohibited. The Administrator's employees are likewise prohibited from engaging in activities related to the Plan while impaired by alcohol or under the influence of illegal or illicit substances. A copy of the Administrator's substance abuse policy is annexed hereto as Exhibit L.

10.6 Intentionally Omitted.

10.7 The Administrator shall establish a Participant Complaint Resolution Procedure, as set out in the Plan, and shall distribute a description of that Complaint Resolution Procedure to Participants.

10.8 This Agreement shall not be modified or amended except in writing, signed by an authorized officer of the Administrator and an authorized officer of the Plan Sponsor. However, the Plan Document, attached as Exhibit "A" to this Agreement may be amended or changed with the approval of the Administrator and the concurrence of the Mayor of the City of Houston, the Plan Sponsor's City Attorney and Human Resources Director. The waiver by a party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation thereof.

10.9 Masculine pronouns used in this Agreement shall include both the masculine and feminine genders.

10.10 A party shall not assign, either at law or otherwise, its rights or obligations hereunder without the prior written consent of the other party. The foregoing prohibition includes assignments by operation of law.

10.11 If any part, term, or provision of this Agreement other than Article VIII shall be held void, illegal or unenforceable, the validity of the remaining portions or provisions shall not be affected thereby.

10.12 In the event that, due to circumstances not reasonably within the control of the Administrator, such as war, riot or a major disaster or epidemic, either the Administrator or the Plan Sponsor is unable to perform its obligations under this Agreement, then it shall not be liable to the other party if it has, in good faith, used its best efforts to perform under the circumstances.

10.13 This Agreement creates no rights on the part of the Participants. It is understood that such persons are not, and shall in no event be construed as, third party beneficiaries of this Agreement and that no privity of contract shall exist between them and the Administrator.

10.14 This Agreement shall be governed by the internal laws of the State of Texas and the Charter and ordinances of the City of Houston. Venue for any litigation related to this Agreement shall be Harris County, Texas.

10.15 Any notice required or permitted to be given under this Agreement shall be deemed delivered if sent by certified mail, return receipt requested, postage prepaid to:

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
2425 West Loop South
Suite 1000
Houston, TX 77027-4208

and to:

The City of Houston
611 Walker - Suite 4A
Houston, Texas 77002
Attn: Human Resources Director

10.16 Administrator shall maintain the confidentiality of information contained in the medical records of Participants or indicating the medical condition of Participants and information received from Physicians, surgeons, Hospitals or other Health Professionals incident to the physician-patient relationship or hospital-patient relationship in accordance with applicable law. Information may not be disclosed by Administrator without written consent of the Participant except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by Administrator in connection with the administration of this Agreement, or in the compiling of aggregate statistical data. Such information that is identifiable with an individual Participant may not be disclosed to Plan Sponsor, in connection with the conduct of appeals or otherwise, without the written consent of the affected Participant.

10.17 Administrator understands that Plan Sponsor has from time to time offered one or more federally sponsored Medicare Advantage Plans to its Medicare eligible Retirees. If Plan Sponsor contracts with one or more providers of such Medicare Advantage Plans, then Plan Sponsor shall allow eligible Participants to elect coverage thereunder rather than through this Plan in connection with initial enrollments or annual enrollment periods. Additionally, if Plan Sponsor's eligible Retirees have enrolled in any such Medicare Advantage Plan and the Medicare Advantage Plan ceases operations or withdraws from the Houston market, then Plan Sponsor shall allow the affected Participants to enroll in this Plan. Furthermore, if any of the Plan's eligible Retirees enroll in any Medicare Advantage Plan offered by Plan Sponsor and then becomes dissatisfied with such coverage, then such Retiree shall be allowed to return to this Plan on the first day of each month. To the extent of any difference, these provisions will be recognized as exceptions to the eligibility requirements under this Plan.

10.18 All of the Exhibits described below are hereby incorporated into this Agreement by this reference for all purposes.

Exhibit "A" - PPO Plan Document
Continuation Coverage Rights Under COBRA
The Women's Health and Cancer Rights Act of 1998
Exhibit "A-1" - Retirees' Hospitalization and Medical-Surgical Program Plan Document
Exhibit "B" - Administrative Charges
Exhibit "C" - Service Area
Exhibit "D" - Directory
Exhibit "E" - Service Performance Standards
Exhibit "E-1" – Service Performance Standards Exhibit
Exhibit "F" - Management Reports
Exhibit "G" - Rates and Guarantees
Exhibit "H" - Stop Loss Policy
Exhibit "H-1" – Stop-Loss Exhibit
Exhibit "I" - Equal Employment Opportunity
Exhibit "J" - Minority and Women Business Enterprises
Exhibit "K" - Allocation and Appropriation of Funds
Exhibit "L" - Drug Policy
Exhibit "L-1" – Drug Policy Compliance Agreement
Exhibit "L-2" – Administrator's Certification of No Safety Impact Positions in Performance of a City Contract
Exhibit "L-3" – Drug Policy Compliance Declaration
Exhibit "M" - Self-Funded PPO Claims Projection Template
Exhibit "N" – Retiree Drug Subsidy Data Exchange Agreement
Exhibit "O" – Recovery Litigation
Exhibit "P" – Health Risk Assessment Credit

Addendum A – Blue Cross and Blue Shield Required Notices and Disclosures
Addendum B – Transfer Payment and Other Financial Responsibilities

10.19 Each party acknowledges the validity of the other party's service marks, trade marks, trade names, copyrights, and other proprietary marks (herein referred to in this section as Proprietary Marks). Administrator acknowledges that the Plan Sponsor's Proprietary Marks are the sole property of the Plan Sponsor and agrees not to contest the Plan Sponsor's ownership of such Proprietary Marks. The Plan Sponsor acknowledges that Administrator's Proprietary Marks are the sole property of the Blue Cross and Blue Shield Association or Administrator and agrees not to contest the Blue Cross and Blue Shield Association's or Administrator's ownership or the license granted to Administrator for use of such Proprietary Marks. Administrator agrees not to infringe upon, dilute, or harm the Plan Sponsor's rights in its Proprietary Marks. The Plan Sponsor agrees not to infringe upon, dilute, or harm the Blue Cross and Blue Shield Association's ownership rights or Administrator's rights as a licensee in its Proprietary Marks. Administrator agrees to submit all material employing the Plan Sponsor's Proprietary Marks in writing to the Plan Sponsor for approval prior to any use. The Plan Sponsor agrees to submit all material employing Administrator's Proprietary Marks in writing to Administrator for approval prior to any use. The Plan Sponsor agrees to furnish the Plan Sponsor's Proprietary Marks in conjunction with Administrator's performance of services under this Agreement. Use of the Plan Sponsor's Proprietary Marks does not vest Administrator with any title, right, or other ownership interest in such Proprietary Marks. Administrator agrees that any goodwill or other benefits Administrator gains from its use of the Plan Sponsor's Proprietary Marks shall inure to the Plan Sponsor's benefit.

10.20 In the event Administrator and the Plan Sponsor exchange data and information electronically, the Plan Sponsor agrees to transfer on a timely basis all required data to Administrator via electronic transmission on the intranet and/or internet or otherwise, in the format mutually agreed to by Administrator and Plan Sponsor. The Plan Sponsor authorizes Administrator to submit such data and information to the Plan Sponsor in the specified electronic format. In the event the Plan Sponsor is unable or unwilling to

transfer data in the specified electronic format, Administrator is under no obligation to receive or transmit data in any other format.

10.21 The Plan Sponsor is hereby notified that it is a Member of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of HCSC. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of this subsection 10.21, the term Member means the group, trust, association or other entity to which this Agreement has been issued. It does not include Participants (employees or their dependents) under the Plan. Plan Sponsor shall not be responsible for any assessments and shall not be eligible for any dividend or distribution.

10.22 AUDIT AND CORRECTION OF AUDIT ERRORS

A. During the term of the Agreement and within one hundred eighty (180) days after the termination of the Agreement, the Employer or an authorized agent of the Employer (as mutually agreed to by the Claim Administrator and the Employer; such agreement not to be unreasonably withheld) may, upon at least ninety (90) days prior written notice to the Claim Administrator, conduct reasonable audits of the Claim Administrator's records in regard to Claim Payments made under the Agreement. Such agent that has access to the information and files maintained by the Claim Administrator will agree not to disclose any proprietary or confidential information, and to hold harmless and indemnify the Claim Administrator in writing of any liability from disclosure of such information. Audits performed on a contingency fee basis will not be allowed or supported by the Claim Administrator. The Employer will be responsible for all costs associated with the inspection or audit. All such audits shall be subject to the Claim Administrator's external audit policy and procedures, a copy of which shall be furnished to the Employer upon request to the Claim Administrator.

B. The Claim Administrator shall be responsible only for the correction of errors identified in specific Claim Payments subject to the terms and conditions of the Agreement and shall not be responsible for errors calculated to exist in a population of Claim Payments on the basis of a sample drawn from that population. Further, the Claim Administrator has the right to implement reasonable administrative practices in the administration of the Agreement. Minor deviations in Claim Payments as a result of a differing opinion regarding benefit interpretation or administrative practices shall not be considered errors. An example of a minor deviation would be allowing the charge when the allowance is not yet determined on a service if it is under a designated amount (i.e., $50).

C. During the term of the Agreement and within one hundred eighty (180) days after the termination of the Agreement, the Claim Administrator may, upon at least thirty (30) days prior written notice to the Employer, conduct reasonable audits of Employer's membership records with respect to eligibility.

10.23 Administrator and Plan Sponsor shall execute a Retiree Drug Subsidy (RDS) Data Exchange Agreement, as set out in Exhibit N, concurrently with the execution of this Agreement.

10.24 In the event the Plan Sponsor directs the Administrator to provide data directly to its third party consultant and/or vendor, the Plan Sponsor acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

1. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 10.23, "Confidential Information").
2. Release of the Confidential Information may also reveal the Administrator's confidential, business proprietary and trade secret information (for purposes of this Section 10.23, "Proprietary Information").
3. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section 10.23, collectively, "Information").
4. The third party consultant and/or vendor shall:

a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Plan Sponsor.

b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Plan Sponsor.

c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.

d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this Agreement or as required by law.

5. Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.

6. The third party consultant and/or vendor shall execute the Administrator's then–current confidentiality agreement.

7. The Plan Sponsor shall designate the third party consultant and/or vendor on the appropriate HIPAA documentation.

8. The Plan Sponsor shall provide the Administrator with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

Administrator and its employees, officers, directors and agents shall have no responsibility for any losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments in connection with any claim based upon the Administrator's disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any Participant at the direction of the Plan Sponsor or breach by the third party consultant and/or vendor of any obligation described in this Agreement.

IN WITNESS HEREOF, and as duly authorized, the parties hereto execute this Agreement in duplicate with the Effective Date herein provided.

ATTEST/SEAL:

By: Jean A. Perkins
Name: JEAN A. PERKINS
Title: ASST SEC'Y.

BLUE CROSS AND BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY

By: _____
Martin G. Foster, President

ATTEST/SEAL:

_____
City Secretary

CITY OF HOUSTON, TEXAS
Signed by:

Bill White
Mayor

APPROVED:

_____
Human Resources Director

COUNTERSIGNED BY:

Annise D. Parker
City Controller

APPROVED AS TO FORM:

_____
Sr. Assistant City Attorney
L.D. File No.

DATE COUNTERSIGNED:

3-21-06

A	Preferred Provider Organization (ASA) PPO Health Program: Plan A
B	Administrative Charges
C	Service Area Map
D	Blue Choice PPO Directory
E	Service Performance Standards
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CITY OF HOUSTON

PREFERRED PROVIDER ORGANIZATION (PPO)
HEALTH PROGRAM

EFFECTIVE MAY 1, 2006

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The provisions of this Plan may be amended at any time, and from time to time, by the City of Houston in accordance with Section VII of this Plan Document. In addition, the City of Houston reserves the right to terminate this Plan at any time in accordance with Section VII.

I. DEFINITIONS

Except as expressly otherwise provided or unless the context otherwise requires, the following words and phrases used in this Plan Document shall have the following meanings:

"Administrator" means the person or entity currently appointed as claims administrator of the Plan by the Plan Sponsor. The current Administrator of this Plan is Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation. The Administrator is not a fiduciary of the Plan.

"Annual Combined Coinsurance/Deductible Maximum Amounts (Annual Maximum)" means the total out-of-pocket payments, other than Copayments, for which a Participant or Subscriber family unit is responsible in each Calendar Year, as more fully described in the Schedule of Benefits, Section 1 and Section 2.

"Alternative Health Benefits Plan" means any comprehensive health benefits plan, other than this Plan, that is offered by, through or in connection with the Plan Sponsor.

"Application" means the forms prescribed by the Administrator that each Eligible Employee, Deferred Retiree, Retiree and Survivor on his own behalf and on behalf of his Eligible Dependents, shall be required to complete and submit to the Administrator for the purpose of enrolling himself and his Eligible Dependents in the Plan.

"BlueCard® Program" means a PPO program offered by Administrator and other participating Blue Cross and/or Blue Shield Plans which enables Participants with In-Area Coverage living or traveling in the Service Area but outside of Texas to receive In-Network Services from Participating Health Care Providers.

"Calendar Year" means the period beginning January 1 of any year and ending December 31 of the same year.

"Child" means (1) the Subscriber's unmarried natural child, foster child, stepchild, legally adopted child or Grandchild; (2) a child whose adoption by the Subscriber is anticipated and for whom the Subscriber has legal support obligations; (3) a child under the Subscriber's legal guardianship; or (4) in the instance of a divorced Subscriber, a child for whom the Subscriber has been ordered to assume medical responsibility in a divorce decree entered by a court of competent jurisdiction. Except in the instance of item (4), the person must reside with the Subscriber in order to be a "Child." Child excludes a person who is on active military duty for any country.

"Childhood Immunization" means an immunization against diphtheria, hemophilus influenzae type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicello and any other vaccination required by law and administered from the date of birth through the sixth birthday.

"Coinsurance" means the percentage of the charge for a Covered Service, as set forth in the Schedule of Benefits, that must be paid by the Participant. Coinsurance requirements are separate from and in addition to any requirements to pay Copayments, Deductibles or Contributions.

"Contributions" means the payments made by the Subscriber on behalf of himself and any Dependents, in order to maintain enrollment in the Plan.

"Copayment" means the dollar charge for a Covered Service, as set forth in the Schedule of Benefits, that must be paid by the Participant. For In-Network Services, the Participant must pay the Copayment to the Participating Health Care Provider at the time the service is rendered. Copayment requirements are separate from and in addition to any requirements to pay Coinsurance, Deductibles or Contributions.

"Craniofacial Abnormality" means an abnormal structure or deformity of the cranial and facial bones caused by congenital defects, developmental deformities, trauma, tumors, infections or disease, including a defect of the upper face or midface, a defect of the midface or lower face, or both.

"Covered Services" means Medically Necessary health care services and supplies, specified as covered in the Schedule of Benefits, that are received by Participants in accordance with the terms and procedures of the Plan. With respect to Participants who have In-Area Coverage, the term "Covered Services" means In-Network Services and Out-of-Network Services. With respect to Participants who have Out-of-Area Coverage, the term "Covered Services" means Out-of-Area Services.

"Custodial Care" means care that primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes) *or* can be given by people other than trained medical personnel. Care can be "Custodial" even if it is prescribed by a physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters.

"Deductible" means the annual dollar amount of the cost of Covered Services, as set forth in the Schedule of Benefits, that must be incurred by a Participant before benefits under the Plan will be available. Deductible requirements are separate from and in addition to any requirements to pay Copayments, Coinsurance or Contributions.

"Deferred Retiree" means an Eligible Deferred Retiree who is enrolled in the Plan, who continues to meet the Deferred Retiree eligibility requirements set forth in this Plan Document, and for whom the Contributions required hereunder have been made in accordance with the terms of this Plan Document.

"Dependent" means an Eligible Dependent who has been enrolled in the Plan by a Subscriber, who continues to meet the Dependent eligibility requirements set forth in this Plan Document, and for whom the Contributions required hereunder have been made in accordance with the terms of this Plan Document.

"Diabetes Equipment" means:

(1) blood glucose monitors, including monitors designed to be used by blind individuals;

(2) insulin pumps and associated appurtenances;

(3) insulin infusion devices; and

(4) podiatric appliances for the prevention of complications associated with diabetes.

"Diabetes Self-Management Training" means diabetes training provided by a health care practitioner or provider who is licensed, registered, or certified in this state to provide appropriate health care services. The term includes:

(1) training provided to a qualified Participant after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified Participant's symptoms or condition that requires changes in the qualified Participant's self-management regime; and

(3) periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

"Diabetes Supplies" means:

(1) test strips for blood glucose monitors;

(2) visual reading and urine test strips;

(3) lancets and lancet devices;

(4) insulin and insulin analogs;

(5) injection aids;

(6) syringes;

(7) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(8) glucagon emergency kits.

"Durable Medical Equipment" or "DME" means equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose, is generally not useful to a person in absence of illness or injury, and is appropriate for use in the home.

"Effective Date" means May 1, 2006.

"Eligible Deferred Retiree" means an Employee of the Plan Sponsor who as a member of one of the various State statutory pension plans that are offered to the Plan Sponsor's employees:

(1) Has completed sufficient service time and/or met any other applicable requirements to be eligible to receive a deferred pension under the terms of the pension plan; and

(2) Will attain the age necessary to commence actually receiving benefit payments under the pension plan on or before the fifth anniversary of the Employee's severance from active service with the Plan Sponsor.

(3) Has been continuously covered under a Group Plan from the Employee's severance from active service with the Group until commencement of a deferred pension under the terms of the pension plan.

"Eligible Dependent" means a Subscriber's Spouse or Primarily Dependent Person. An Eligible Dependent is only eligible to enroll in the type of coverage under the Plan that such Dependent's Subscriber is eligible to enroll in.

"Eligible Employee" means a person who:

(1) regularly renders personal services not less than thirty (30) hours per week in the paid employment of the Plan Sponsor or who is the Mayor, a City Council Member or the City Controller of the Plan Sponsor; and

(2) has been employed or in office, as the case may be, for at least ninety (90) days.

The term "Eligible Employee" includes persons who meet the foregoing criteria and who, for a period of time not to exceed twelve (12) months, are on leave of absence approved by the Plan Sponsor.

"Eligible Retiree" means an individual who has retired from the service of the Plan Sponsor and is receiving retirement benefit payments under one of the several pension plans offered by the Plan Sponsor.

"Emergency Care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that

failure to get immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Employee" means an Eligible Employee who is enrolled in the Plan, who continues to meet the Employee eligibility requirements set forth in this Plan Document, and for whom the Contributions required hereunder have been made in accordance with the terms of this Plan Document.

"Experimental/Investigational" means the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. "Approval" by a Federal agency means that the treatment procedure, facility, equipment, drug or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, "medical treatment" includes medical, surgical or dental treatment. "Standard medical treatment" means the services or supplies that are in general use in the medical community in the United States, and: (1) have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated; (2) are appropriate for the Hospital or Health Care Provider in which they were performed; and (3) the Physician or Health Care Provider has had the appropriate training and experience to provide the treatment or procedure. Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination. Although a Physician or Health Care Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, such services or supplies still may be considered to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

"Grandchild" means a natural or adopted grandchild of the Subscriber who is Primarily Dependent on the Subscriber. The Subscriber will be required to document to the satisfaction of the Plan Sponsor that the Grandchild is Primarily Dependent on the Subscriber.

"Group Enrollment Period" means a period of at least thirty-one (31) consecutive days per Plan year, conducted from time to time, during which:

(1) members of Alternative Health Benefits Plans who are eligible for enrollment as Subscribers in this Plan may submit an Application;

(2) Subscribers may elect to change from this Plan to an Alternative Health Benefits Plan for which they are eligible;

(3) Subscribers may disenroll from the Plan or drop Dependents from the Plan; and

(4) persons who are not Subscribers or are not covered under an Alternative Health Benefits Plan may apply for coverage under the Plan in accordance with Section II.B.4 of this Plan Document.

"Health Care Provider" means a Physician, Hospital, pharmacy or other professional person or facility licensed or otherwise duly authorized to provide health care services under the laws of the jurisdiction in which such provider or facility renders the services. The term "Health Care Provider" includes, but is not limited to, In-Network Health Care Providers.

"Hospital" means:

(1) an institution that is operated pursuant to state law and is primarily engaged in providing, on an inpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and major surgical services, all of which services must be provided on its premises under the supervision of a staff of Physicians and with twenty-four (24) hour a day registered nursing service; or

(2) an institution that does not meet all of the foregoing requirements but that does meet state licensing requirements and is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

In no event shall the term "Hospital" include a convalescent home, nursing home or any other institution or part thereof that is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged or extended care facility, intermediate care facility, skilled nursing facility or facility primarily for rehabilitative services; the term "Hospital" shall include treatment in a residential treatment center for children and adolescents and treatment provided by a crisis stabilization unit.

"In-Area Coverage" means the type of coverage available under the Plan to (i) Subscribers who are Employees, Survivors, Deferred Retirees and Retirees who Reside in the Service Area, and (ii) the Dependents of such Subscribers. In-Area Coverage consists of In-Network Services and Out-of-Network Services.

"In-Network Services" means Covered Services, as specified in the Schedule of Benefits, that are:

(1) provided by a Participating Health Care Provider (or, with prior written authorization from the Administrator, by a Non-Participating Health Care Provider), and otherwise pre-approved in writing by the Administrator as required in the Schedule of Benefits; or

(2) Emergency Care provided by Health Care Providers.

"Life Threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Lifetime Maximum Benefit" means the maximum lifetime amount of benefits payable to or on behalf of a Participant. The total lifetime benefit shall be computed by adding all amounts payable under the Plan, any Alternative Health Benefits Plan, and any comprehensive health benefits policy, plan or program formerly offered by the Plan Sponsor, whether insured or self-funded.

"Medical Director" means the licensed Physician in the full or part time employ of the Administrator, and such other licensed Physician(s) as the Medical Director may designate, who are responsible for overseeing medical matters arising in connection with the Plan.

"Medical Emergency" means a medical condition necessitating Emergency Care.

"Medically Necessary," as applied to a health care service, means that the service meets all of the following conditions:

(1) the service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;

(2) if the Participant is ill or injured, the service is needed in order to keep the Participant's condition from getting worse;

(3) the service is generally accepted as safe and effective under standard medical practice in the community;

(4) the service is not primarily for the convenience of the Participant, his Physician, or Health Care Provider; and

(5) the service is provided in the most cost-efficient way, while still giving an appropriate level of care.

"Medicare" means Title XVIII of the Social Security Act and regulations thereunder.

"Non-Participating," as applied to any Health Care Provider, means that the Health Care Provider is not under contract with the Administrator (or, in some instances, with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider to provide Covered Services to Participants.

"Non-Preferred Drug" means a name brand prescription drug product that does not appear and the Preferred Drug list and may be subject to the Non-Preferred Drug Copayment.

"Out-of-Area Coverage" means the type of coverage, consisting of Out-of-Area Services, that is available under the Plan to Subscribers who Reside outside the Service Area, and the Dependents of those Subscribers.

"Out-of-Area Services" means Covered Services, as specified in the Schedule of Benefits, rendered to Subscribers who have Out-of-Area Coverage and to the Dependents of those Subscribers. Out-of-Area Services are only available to those Participants who have Out-of-Area Coverage.

"Out-of-Network Services" means Covered Services, other than Out-of-Area Services, that are:

(1) not provided by a Participating Health Care Provider (except that the Administrator may, under certain circumstances specified in the Schedule of Benefits, authorize services not provided by a Participating Health Care Provider to be treated as In-Network Services); or

(2) not pre-approved by the Administrator as required for In-Network Services in the Schedule of Benefits.

"ParPlan" means a contractual arrangement between Administrator (or other Blue Cross and/or Blue Shield Plans) and certain Health Care Providers whereby such Health Care Providers agree to accept a discounted rate as payment in full for Covered Services rendered.

"ParPlan Provider" means a Non-Participating Health Care Provider who participates in Administrator's ParPlan or in the ParPlan of other participating Blue Cross and/or Blue Shield Plans. If a Non-Participating Health Care Provider participates in ParPlan, the Non-Participating Health Care Provider agrees to: (1) file all claims for Participant; (2) accept the Administrator's Usual and Customary Charges as payment for Medically Necessary Covered Services; and (3) not bill Participant for Covered Services over the Usual and Customary Charge determination. Participant will be responsible for any applicable Deductibles, Coinsurance, or services that are not Covered Services.

"Participant" means any Subscriber or Dependent.

"Participating," as applied to any Health Care Provider, means that the Health Care Provider is under contract with the Administrator (or, in some instances, with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider to provide Covered Services to Participants.

"Physician" means an individual licensed by the appropriate state or jurisdiction to practice as a physician within the scope of his license.

"Physician Office Visit" means services rendered in the office of a Primary Physician or Specialist.

"Plan" is the plan of health care coverage offered by the Plan Sponsor, administered by the Administrator and described in this Plan Document.

"Plan Document" means this plan document, the Schedule of Benefits and all applicable attachments.

"Plan Sponsor" means the City of Houston.

"Preferred Drug" means a name brand prescription drug product that is preferred by Administrator and that is subject to the Preferred Drug Copayment. Preferred Drugs are identified on the Preferred Drug list which is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles. Administrator will periodically review the Preferred Drug list and adjust it to modify the Preferred/Non-Preferred Drug status of new and existing drugs. Changes to the Preferred Drug list would be implemented on the next renewal date of the Plan. The Preferred Drug list and any modifications thereto will be made available to Participants. Participants may also contact Administrator to determine if a particular drug is on the Preferred Drug list. Drugs that do not appear on the Preferred Drug list may be subject to the Non-Preferred Drug Copayment.

"Primarily Dependent" means receiving more than fifty percent (50%) of his or her support from the Subscriber, meeting the requirements to be claimed as a dependent on the Subscriber's federal income tax return and being a dependent Child.

"Primarily Dependent Person" means a Child who is:

(1) under twenty-five (25) years of age and Primarily Dependent on the Subscriber; or

(2) any age and incapable of self-sustaining employment because of mental retardation or physical handicap provided: (i) such Child was an enrolled Participant prior to attainment of the limiting age; and (ii) Subscriber furnishes the Administrator proof of the incapacity and dependency within thirty-one (31) days after the occurrence of the incapacity and from time to time thereafter as the Administrator deems appropriate.

"Primary Physician" means a Physician who is primarily an Internist, Obstetrician/Gynecologist, Pediatrician, or Family Practice Physician.

"Professional Other Provider" means a provider other than a Physician including a dentist, nurse, audiologist, podiatrist, osteopath, optometrist, physician's assistant, nurse first assistants, acupuncturists, clinical psychologist, social worker, pharmacist, nutritionist, physical therapist, speech therapist or other professional engaged in the delivery of health services who is licensed, practices under an institutional license, is certified or practices under the authority of a Physician or legally constituted professional association or other authority consistent with the laws of the State.

"Qualified Individual" means a member who is (i) a postmenopausal woman who is not receiving estrogen replacement therapy; (ii) an individual with vertebral abnormalities; primary hyperparathyroidism or a history of bone fractures; or (iii) an individual who is receiving long-term glucocorticoid therapy or is being monitored to assess the response to or efficacy of an approved osteoporosis drug (See Schedule of Benefits, Section 2, **What is Covered, Preventive Services.)**

"Residence" means the Participant's primary residence. The availability of benefits to a Dependent is based upon the Residence of the Subscriber through whom he is enrolled.

"Retiree" means an Eligible Retiree who is enrolled in the Plan, who continues to meet the Retiree eligibility requirements set forth in this Plan Document, and for whom the Contributions required hereunder have been made in accordance with the terms of this Plan Document.

"Schedule of Benefits" means the schedule provided with this Plan Document, and made a part hereof, which sets forth the Covered Services.

"Serious Mental Illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(1) schizophrenia;

(2) paranoid and other psychotic disorders;

(3) bipolar disorders (hypomanic, manic, depressive, and mixed);

(4) major depressive disorders (single episode or recurrent);

(5) schizo-affective disorders (bipolar or depressive);

(6) pervasive developmental disorders;

(7) obsessive-compulsive disorders; and

(8) depression in childhood and adolescence.

"Service Area" means the geographical area in which a network of Participating Health Care Providers is offered and available and is used to determine eligibility for In-Area Coverage under the Plan. The Service Area includes Administrator's preferred provider organization (PPO) service area in Texas as well as the PPO service areas of other participating Blue Cross and/or Blue Shield Plans outside of Texas.

"Specialist" means a Physician or Professional Other Provider who has entered into an agreement with the Claims Administrator to participant as a Provider of specialty services.

"Spouse" has the meaning ascribed by law, but excludes a spouse who is on active military duty for any country or who is legally separated from a Subscriber.

"Subscriber" means an Employee, Survivor, Retiree or Deferred Retiree.

"Survivor" means a Dependent whose coverage is continued in the event of termination of a Subscriber's coverage due to the death of the Subscriber, following the date of the Subscriber's death, provided that the Subscriber's surviving Spouse or, in the absence of such a surviving Spouse, the Subscriber's eldest Dependent, shall be deemed to be the Subscriber for purposes of the Plan, and further provided that the Contributions required with respect to all such Dependents of the deceased Subscriber are made. Coverage for such Dependents shall terminate on the earliest of the following dates:

(1) the last day of the month in which the Dependent marries or remarries (but this event shall only terminate coverage of the Dependent who is marrying or remarrying, and not the coverage of the other Dependents);

(2) as to any Dependent Child of the deceased Subscriber, the last day of the month in which such Dependent Child ceases to be a Dependent as defined in this Plan;

(3) the last day of the month in which the Dependent becomes eligible for coverage hereunder as an Eligible Employee, or becomes eligible for coverage under any employer-sponsored policy, plan or program of group health coverage; or

(4) upon the date of termination of this Plan.

Coverage under this definition shall be limited to Dependents who were covered at the time of the Subscriber's death, except that coverage may also be extended to any newborn natural Child of the deceased Subscriber in accordance with the provisions of Section II.C of this Plan Document that pertain to newborn children. Notwithstanding the foregoing, if the Revised Civil Statutes of Texas

would entitle a Survivor under this definition to expanded eligibility under the Plan, then such Survivor shall be eligible in accordance with that Article for so long as it applies to that Survivor.

"Usual and Customary Charges" means the maximum amount eligible for consideration of payment for Covered Services.

For In-Network Services, Usual and Customary Charges are based on the provisions of the Participating Health Care Provider's contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), relative value, fee schedule, per diem or other.

For Out-of-Area Services and Out-of-Network Services, in those instances in which the Health Care Provider is a ParPlan Provider, Usual and Customary Charges shall be the negotiated charge for the Covered Services. (The ParPlan Provider may bill the recipient for any portion of the negotiated charge that is not covered by the Plan, such as applicable copayment, coinsurance, or deductible amounts).

For Out-of-Area Services and Out-of-Network Services provided by Health Care Providers who are not ParPlan Providers, Usual and Customary Charges shall be the lesser of:

(1) The charge made by the Health Care Provider for the Covered Services; or

(2) The charge most other Health Care Providers in the same locality where the Covered Services were provided would make for the Covered Services; for purposes of determining this amount, the Plan Sponsor shall utilize then current data applicable to the service locality as published in the Prevailing Health Care Charges System (currently published by Ingenix and formerly published by the Health Insurance Association of America) at the 70th percentile.

II. ELIGIBILITY; EFFECTIVE DATE OF COVERAGE

A. Eligibility

1. To be eligible to enroll as a Subscriber in this Plan, a person must not be covered or eligible for coverage under extended benefits coverage of any other health plan, and must be within one of the following categories:

   (i) an Eligible Employee,

   (ii) an Eligible Deferred Retiree,

   (iii) an Eligible Retiree, or

   (iv) a Survivor.

2. To be eligible to enroll as a Dependent in this Plan, a person must not be covered or eligible for coverage under extended benefits coverage of any other health plan, and must be within one of the following categories:

   (i) the Spouse of a Subscriber, or

   (ii) a Primarily Dependent Person of a Subscriber.

3. Omitted

4. Notwithstanding the foregoing, a person may be covered only as a Subscriber or a Dependent, but not both simultaneously. If and when a person terminates coverage under the Plan as either a Subscriber or Dependent, the person shall have the right to continue coverage under the definition that continues to apply, if any.

5. In addition to any other criteria, the availability of coverage for a Deferred Retiree or Retiree shall be limited to persons who held coverage under the Plan, an Alternative Health Benefits Plan, or any comprehensive health benefits policy, plan or program

formerly offered by the Plan Sponsor, as an employee at the time they first elected to assume deferred retiree or retiree status with the Plan Sponsor and who thereafter have continuously maintained coverage. Coverage of Dependents of Deferred Retirees and Retirees shall also be so restricted, except that newly acquired Eligible Dependents may become Participants in accordance with the provisions related to Newly Acquired Dependents at Section II.C.2.

B. Application for Coverage as Subscriber; When Subscriber Coverage Becomes Effective

1. During the Initial Group Enrollment Period, for Persons Already Covered

Each person eligible for enrollment as a Subscriber under Section II.A.1 above, who is already covered under an Alternative Health Benefits Plan and who submits an Application during the Initial Group Enrollment Period to be held in advance of the Effective Date, shall become covered under the Plan as a Subscriber on the Effective Date.

2. During Subsequent Group Enrollment Periods, for Persons Already Covered

Each person eligible for enrollment as a Subscriber under Section II.A.1 above, who is already covered under this Plan or an Alternative Health Benefits Plan and who submits an Application during a subsequent Group Enrollment Period, shall become covered under the Plan as a Subscriber (or shall transfer between types of coverage for which the person is eligible, if he is already a Subscriber) on the date specified in connection with the enrollment.

3. Newly Eligible Employees and Survivors

Each person who first meets the requirements for enrollment as an Eligible Employee or Survivor under Section II.A.1 above at a time that is not during a Group Enrollment Period may enroll within thirty-one (31) days of meeting such requirements by submitting an Application. Such person shall become covered under the Plan as a Subscriber on the first day of the month following submission of the Application.

4. During Group Enrollment Periods, for Persons Not Already Covered

During a Group Enrollment Period (including the Initial Group Enrollment Period), a person who would otherwise be eligible to be a Subscriber but who is not enrolled as a Subscriber in the Plan or an Alternative Health Benefits Plan may apply for enrollment in the Plan by submitting an Application. Coverage shall commence on the sixteenth (16th) day of the calendar month or the first day of the next month (whichever is sooner) following the expiration of ninety (90) days after submission of the Application, or on such other date as the Plan Sponsor may specify in calling the Group Enrollment Period.

C. Application for Coverage as Dependent; When Dependent Coverage Becomes Effective

1. When Subscriber Becomes Covered

An Eligible Dependent included on a person's Application submitted in accordance with Sections II.B.1, II.B.2 or II.B.3 of this Plan Document shall become covered under the Plan as a Dependent on the date that the Subscriber becomes covered under the Plan, provided that the Eligible Dependent meets the same criteria specified in Sections II.B.1, II.B.2 or II.B.3 for Subscribers, as applicable.

2. Newly Acquired Dependents

a. A Subscriber's newly acquired Spouse or stepchild, on whose behalf the Subscriber has submitted an Application within thirty-one (31) days of the marriage, shall be covered as of the date of the marriage.

b. A newborn natural Child of Subscriber shall be covered under the Plan for an initial

period of thirty-one (31) days from the date of birth, and shall continue to be covered after that time if, prior to the expiration of the thirty one (31) day period, the Subscriber submits an Application for the newborn Child.

c. A Child of the Subscriber who is not a newborn natural Child or a newly acquired stepchild shall be covered under the Plan if the Subscriber submits an Application on behalf of such Child as follows:

(i) In the case of a Grandchild, the Application must be submitted within thirty-one (31) days after the date when the Grandchild becomes Primarily Dependent on the Subscriber. If the Application is submitted within thirty-one (31) days of the date when the foregoing condition is first met, coverage shall commence as of the date the Grandchild becomes Primarily Dependent on the Subscriber.

(ii) In the case of an adopted child, foster child, child under Subscriber's legal guardianship or child whose adoption by the Subscriber is anticipated and for whom the Subscriber has legal support obligations, the Application must be submitted within thirty-one (31) days after the earlier of the date upon which the child commences residence with the Subscriber, the date when the Subscriber undertakes a legal obligation to provide the total or partial support of the child or the date when a Court orders the child be covered by the Subscriber, and coverage shall begin on the earlier date provided the Application is submitted on a timely basis.

(iii) In the case of a dependent Child who has lost coverage under Title XIX of the Social Security Act or the Texas Children's Health Insurance Program ("CHIP"), other than coverage consisting solely of benefits under Section 1928 of the Act (42 U.S. C. Section 1396s) or under Chapter 62, Health and Safety Code, the Application must be submitted within thirty-one (31) days after such Child's loss of coverage. If the Application is submitted within thirty-one (31) days of such loss of coverage and the subscriber declined coverage for the child in writing stating that coverage under Medicaid or CHIP was the reason for declining coverage, coverage shall commence on the date of such loss of coverage.

3. During Group Enrollment Periods, for Eligible Dependents Not Previously Covered:

During a Group Enrollment Period, a Subscriber may submit an Application on behalf of an Eligible Dependent who is not enrolled. Coverage shall commence on the sixteenth (16th) day of the calendar month or the first day of the next month (whichever is sooner) following the expiration of ninety (90) days after submission of the Application, or on such other date as the Plan Sponsor may specify in calling the Group Enrollment Period.

D. In no event shall the Plan cover any health care services rendered prior to the date when the Participant's coverage becomes effective or after the date such coverage terminates pursuant to this Plan Document. To the extent that any of the foregoing provisions allows retroactive coverage to be extended, the availability of coverage shall be subject to payment of any required contributions retroactively to the effective date.

E. Notification of Ineligibility

A condition of participation in the Plan is Subscriber's agreement to notify the Plan Sponsor of any changes in status that affect the eligibility of the Subscriber or any of his Dependents hereunder.

F. Clerical Error

1. Clerical error by the Administrator or Plan Sponsor shall not deprive any eligible

individual of coverage under the Plan, provided that the individual's Application and any related materials (such as evidence of insurability or proof of financial dependence) have been submitted on a timely basis, the Administrator has accepted the Application and related material as satisfactory, and all required Contributions have been made.

2. Clerical error by the Administrator or Plan Sponsor shall not extend coverage beyond the date it would otherwise terminate pursuant to the terms of this Plan Document.

G. The provisions of this Section II shall not be construed to preclude special enrollments of Subscribers or Dependents or transfers of Subscribers and Dependents between Alternative Health Benefits Plans at times other than as specified above or to preclude the extension of coverage at times sooner than as specified above where such enrollment or time of taking effect is afforded in order to comply with state or federal laws and regulations regarding the portability of health insurance coverage, the provision of health insurance coverage to children under court orders, residency relocations that affect eligibility, changes in Plan Service Area, and any other provisions of law that preempt the literal application of this Section II or affect eligibility in the Plan or an Alternative Health Benefits Plan. The Administrator, in consultation with the Plan Sponsor's Human Resources Director may, from time to time, promulgate any supplemental provisions regarding eligibility, effective dates and related issues that are necessary or desirable to ensure that the Plan conforms to applicable laws and regulations. No person may be enrolled in the Plan as a Subscriber or Dependent, except under the foregoing provisions of Section II and the aforesaid supplemental provisions.

III. TERMINATION OF COVERAGE OF INDIVIDUAL PARTICIPANTS

A. Employees

Subject to any right to continue coverage under Section XIII of this Plan Document, the coverage of any Employee under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.

2. The end of the last semi-monthly period for which the Employee is current in his Contributions.

3. The last day of the semi-monthly period coinciding with or next following the day on which the Employee ceases to be eligible for coverage under this Plan.

4. The last day of the semi-monthly period coinciding with or next following the day on which the Employee ceases to be employed by the Plan Sponsor, unless the Employee qualifies for and continues coverage hereunder as a Deferred Retired Employee or Retiree. For this purpose, an Employee who is on a leave of absence, not to exceed twelve (12) months, that has been approved by the Plan Sponsor, has not ceased to be employed by the Plan Sponsor.

5. The date of termination of the Employee by the Administrator for fraud, misrepresentation or misconduct as provided in Section III.E below.

6. The end of a semi-monthly period, at the request of the Employee.

B. Deferred Retirees

Subject to any right to continue coverage under Section XIII of this Plan Document, the coverage of any Deferred Retiree under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.

2. The end of the last month for which the Deferred Retiree is current in his Contributions.

3. The last day of the month coinciding with or next following the day on which the Deferred Retiree ceases to be eligible for coverage under this Plan as a Deferred Retiree, by attaining the age necessary to become eligible for pension benefits or otherwise, unless the Deferred Retiree qualifies for and continues coverage hereunder as a Retiree.

4. The date of termination of the Deferred Retiree by the Administrator for fraud, misrepresentation or misconduct as provided in Section III.E below.

5. The end of a month, at the request of the Deferred Retiree.

C. Retirees

Subject to any right to continue coverage under Section XIII of this Plan Document, the coverage of any Retiree under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of this Plan.

2. The end of the last month for which the Retiree is current in his Contributions.

3. The date of termination of the Retiree by the Administrator for fraud, misrepresentation or misconduct as provided in Section III.E below.

4. The end of a month, at the request of the Retiree.

D. Dependents

Subject to any right to continue coverage under Section XIII of this Plan Document, the coverage of any Dependent under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.

2. The date of discontinuation of coverage for such Dependents under the Plan.

3. The date that the Dependent becomes covered as an Employee under the Plan.

4. The date of the termination of coverage of the Subscriber, through whom the Dependent is enrolled in the Plan, provided that coverage may be continued as a Survivor in the event that the Subscriber has died.

5. The last day of the month coinciding with or next following the day on which the Dependent ceases to be eligible for coverage under the Plan.

6. If the Administrator or the Plan Sponsor's Human Resources Director makes a written request to the Subscriber through whom the Dependent is enrolled in the Plan to furnish proof of the eligibility of the Dependent, and the Subscriber fails to furnish the proof within thirty (30) days after receipt of the request, the Dependent's coverage shall terminate upon further written notice from the Administrator or the Plan Sponsor to the Subscriber, provided that the termination shall not take effect until at least fifteen (15) days after the further notice is mailed to the last known address of the Subscriber.

7. The date of termination of the Dependent by the Administrator for fraud, misrepresentation or misconduct as provided in Section III.E below.

E. Termination by the Administrator

Coverage of a Participant may be terminated by the Administrator as follows:

1. In the case of fraud or material misrepresentation by a Participant in connection with the Plan, coverage may be terminated retroactively as of the time when the fraud or misrepresentation occurred, after not less than fifteen (15) days written notice from the Administrator to the Participant.

2. In the case of fraud by a Participant in the use of Covered Services, including without limitation permitting the improper use of a Plan identification card as described in Section VI of this Plan Document, coverage may be terminated retroactively as of the time when the fraud occurred, after not less than fifteen (15) days written notice from the Administrator to the Participant.

3. In the case of misconduct by a Participant detrimental to safe Plan operations and the delivery of Covered Services, coverage may be terminated immediately, upon written notice from the Administrator to the Participant.

4. In the absence of fraud, all statements made by a Subscriber applying for coverage under this Plan will be deemed representations and not warranties. Coverage can be voided for fraud or intentional misrepresentation contained in a written application. A copy of the written application must be furnished to the Subscriber if the terms of the application or enrollment form are to be applied.

IV. SPECIAL REQUIREMENTS FOR PARTICIPANTS COVERED UNDER MEDICARE

A. The Plan shall be the primary payor, as compared to Medicare, when an Employee age 65 or older is enrolled in Medicare. The Plan shall also be the primary payor, as compared to Medicare, when an Employee's Dependent age 65 or older is enrolled in Medicare.

B. The Plan shall be the primary payor, as compared to Medicare, for a period of thirty (30) months, for Participants who have become entitled to Medicare solely on the basis of end stage renal disease. The thirty (30) month period begins the first month in which the individual became entitled to Medicare coverage.

C. When a Participant is covered under Part A and/or Part B of Medicare and Medicare is the primary payor as compared to the Plan, the Administrator shall pay on behalf of that Participant all Medicare deductible and coinsurance payments applicable to services covered by Medicare that would also be Covered Services. The Participant shall remain liable, however, for the Copayments, Coinsurance and Deductibles set forth in the Schedule of Benefits. If that Participant is eligible for Medicare Part A and/or Part B but has not enrolled in such coverage, his claims shall be treated by the Administrator as though the Participant had enrolled in such Medicare coverage.

D. When any benefits are available as primary benefits to a Participant under Medicare, Medicare will be determined first and benefits available under this Plan, if any, will be adjusted accordingly.

V. PARTICIPANT PAYMENT REQUIREMENTS

A. Participant Contributions shall be established from time to time by the Plan Sponsor, and shall be due and payable as determined by the Plan Sponsor. By enrolling in this Plan, the Subscriber agrees to pay all Contributions at such time and in such manner as may be established by the Plan Sponsor.

B. Participants must pay any Copayments, Coinsurance and Deductibles on a timely basis. Combined Coinsurance/Deductible Maximum Amounts may apply as specified in the Schedule of Benefits.

VI. IDENTIFICATION CARDS

Possession of a Plan identification card in and of itself confers no rights to Covered Services. The holder of the card and the name on the card must be the same and the holder of the card must be, in fact, a Participant on whose behalf all applicable Contributions under the Plan have actually been paid. Any person receiving services or other benefits to which he is not entitled, through use of the identification card or otherwise, shall be required to pay the actual cost of services and benefits received. If a Participant permits the use of his identification card by any other person, this card may be recalled and invalidated by the Administrator, and all rights of that Participant pursuant to this Plan Document may be terminated in accordance with Section III.E of this Plan Document. The remedies specified in this Section are not exclusive, and the Plan Sponsor reserves the right to pursue any action against persons who misuse or suffer the misuse of Plan identification materials.

VII. TERMINATION AND AMENDMENT OF PLAN DOCUMENT

A. Termination

The Plan Sponsor reserves the right to terminate the Plan at any time. After the termination of the Plan, benefits payable under the Plan in connection with any claim that arose prior to the date of termination shall be paid in accordance with the terms of the Plan as in existence at the time of termination, subject to the Plan Sponsor's allocation of funds to pay those claims.

B. Amendment

1. The provisions of the Plan may be amended at any time, and from time to time, by the Plan Sponsor upon concurrence of the Plan Sponsor's Mayor, Human Resources Director and City Attorney; provided, however, that no amendment shall deprive any Participant of any benefits to which he became entitled in connection with any claim incurred before the date of the amendment, subject to the Plan Sponsor's allocation of funds to pay those claims.

2. The provisions of the Plan may be amended at any time, and from time to time, by the Plan Sponsor upon concurrence of the Plan Sponsor's Mayor, Human Resources Director and City Attorney; to address the implementation under the Medicare Modernization Act of the Medicare prescription drug benefit (Medicare Part D).

3. The provisions of the Plan may be amended at any time, and from time to time, by the Plan Sponsor upon concurrence of the Plan Sponsor's Mayor, Human Resources Director and City Attorney; in order to comply with state, federal, or local law.

VIII. HEALTH CARE SERVICES

Services Covered by the Plan

The Plan consists of two types of coverage: In-Area Coverage and Out-of-Area Coverage. The definitions of In-Area Coverage and Out-of-Area Coverage in Section I of this Plan Document specify which Subscribers may receive which type of coverage for themselves and their Dependents. Only Subscribers who are determined by the Plan Sponsor to reside outside the Service Area will be entitled to receive Out-of-Area Coverage.

The Covered Services included in In-Area Coverage are In-Network Services and Out-of-Network Services as described in the Schedule of Benefits. The Covered Services included in Out-of-Area Coverage are limited to Out-of-Area Services as described in the Schedule of Benefits.

The Plan shall cover In-Network Services, Out-of-Network Services and Out-of-Area Services in accordance with the terms and procedures and subject to the limitations and exclusions specified in the Schedule of Benefits and in this Plan Document. The Administrator shall arrange for the provision of the In-Network Services.

IX. CLAIM PROVISIONS

A. Reimbursement Claims for services Paid for by Participants

If the Participant furnishes to the Administrator written proof of claim for services that would otherwise be payable by the Plan in accordance with its terms, reimbursement for the payment will be made to the Participant, but without prejudice to the Administrator's right to seek recovery from the Health Care Provider of any payment made by the Plan before the Administrator received the claim. Claims for reimbursement must be made in writing in a form acceptable to the Administrator. Claims and their supporting proof must be furnished to and received by the Administrator within twelve (12) months after the service for which reimbursement is sought was rendered. All of those claims will be paid within sixty (60) days of receipt of complete documentation, unless the Participant is notified of the need for a longer time pursuant to subsection B below.

B. Action on Reimbursement Claims

The Administrator shall endeavor in good faith to process claims for reimbursement in accordance with the following time frames:

1. A claim for which benefits are not assigned or payment is not made directly to the Physician or Provider shall be acknowledged not later than the 15th day after receipt by the Administrator. The claimant shall be notified in writing of the acceptance or rejection of the claim not later than the 15th business day after the date the Administrator receives all items, statements, forms and other supporting materials required. If the claim is rejected, the notice shall state the reasons for rejection and advise the claimant of the dispute procedures of Section XIV.

2. If a claim cannot be accepted or rejected within 15 days after receipt, the claimant shall be so notified not later than the 15th day and the reasons the Administrator needs additional time shall be given, but the Administrator shall accept or reject the claim not later than the 45th day after the date of the notice that the claim cannot be accepted or rejected. If the claimant has not received notice of acceptance or rejection within the 45-day period, the claim will be considered denied on the 45th day of that period.

C. Review; Legal actions; Liability

1. If a claim for reimbursement is denied, a Participant may obtain a review of the denial through the Participant Complaint Resolution Procedure process (See Section XIV).

2. No action at law or in equity (or arbitration proceeding, if arbitration is required in lieu of judicial legal action under provisions applicable to the Plan) shall be brought against the Administrator or the Plan Sponsor: (i) prior to the exhaustion of the remedies available under Section XIV, or (ii) later than three (3) years after the expiration of the period of time in which the proof of the charge or loss is required under this Section to be furnished to the Administrator.

3. No liability shall be imposed upon the Administrator or the Plan Sponsor other than for the benefits and services specifically covered hereunder.

D. Warrants issued in payment of claims shall be mailed to the address of the claimant as stated on the claim form. If the warrant is returned in the U.S. Mail or is not timely presented for payment by its expiration date, the Plan Sponsor and the Administrator shall make a reasonable effort to locate the claimant and reissue the warrant. However, the right to claim any benefit hereunder shall terminate and all rights shall revert to the Plan Sponsor unless the claimant contacts the Plan Sponsor or the Administrator and obtains a replacement warrant within one year from the original date of issuance of the claim warrant.

X. LIMITATIONS

The rights of Participants and obligations of Administrator, Participating Physicians, and Participating Health Care Providers under this Plan Document are subject to the following limitations:

A. Major Disaster or Epidemic

In the event of any major disaster or epidemic that would severely limit the ability of Participating Health Care Providers to provide health care services on a timely basis, Participating Health Care Providers shall, in good faith, use their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available. If the Plan Sponsor, Administrator, and Participating Health Care Providers shall have, in good faith, used their best efforts to render benefits and services in the aforesaid manner, they shall have no further liability or obligation for delay or failure to provide such benefits and services due to a shortage of available facilities or personnel resulting from such disaster or epidemic.

B. Circumstances Beyond Plan Sponsor's, Administrator's or Participating HealthCare Provider's Control

In the event that, due to circumstances not reasonably within the control of Plan Sponsor, Administrator, or Participating Health Care Providers such as the complete or partial destruction of facilities because of war, riot, civil insurrection, or the rendering of benefits and services covered hereunder is delayed or rendered impractical, neither the Plan Sponsor, Administrator, nor any Participating Health Care Providers shall have any liability or obligation on account of such delay or such failure to provide such benefits and services if they shall have, in good faith, used their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available.

C. Limitations as Set Out in the Schedule of Benefits

The benefits provided in this Plan Document are also limited by the limitations and exclusions as set out in the Schedule of Benefits.

D. Non-Covered Services

Administrator shall not be responsible for the reimbursement for services or treatment of complications that result from any non-covered service, procedure or treatment. Administrator shall not be responsible for prescription drugs and/or medications related to any non-covered service, procedure or treatment.

XI. COORDINATION OF BENEFITS

If any benefits to which a Participant is entitled under the Plan are also covered under any other Health Care Plan, the benefits payable under the other Health Care Plan include the benefits that would have been payable under the Plan had claim been duly made therefore. This provision does not apply to Medicaid.

A. For purposes of this Section only, the following words and phrases shall have the following meanings:

1. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Care Plans covering the person for whom claim is made. When a Health Care Plan (including the Plan) provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

2. "Health Care Plan" means any of the following (including the Plan) that provide benefits or services for, or by reason of, medical care or treatment:

a. Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law.

b. Group or individual coverage, including automobile insurance, individual coverage or any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any prepayment coverage, group practice basis or individual practice coverage and any coverage for students that is sponsored by, or provided through, a school or other educational institution above the high school level.

The term "Health Care Plan" shall be construed separately with respect to:

(i) Each policy, contract or other arrangement for benefits or services.

(ii) That portion of any policy, contract or other arrangement that reserves the right to take the benefits of other Health Care Plans into consideration in determining its benefits and that portion that does not.

B. The benefits provided under the Plan will not duplicate benefits that have been provided under another Health Care Plan. If a Participant received benefits from another Health Care Plan on a primary basis, then the Plan will provide benefits on a secondary basis, which will result in the Participant's receiving the level of benefits he would have received had he not received payments from another Health Care Plan. In these instances the Plan will not provide benefits that will result in the Participant receiving 100% coverage unless he would have received 100% coverage from the Plan had he not received benefits from another Health Care Plan.

C. The Administrator shall have the right to coordinate benefits between the Plan and any other Health Care Plan covering the Participant.

The rules establishing the order of benefit determination between the Plan and any other Health Care Plan covering the Participant on whose behalf a claim is made are as follows:

1. The benefits of a Health Care Plan that does not have a "coordination of benefits with other health plans" provision shall, in all cases, be determined before the benefits of the Plan.

2. If, according to the rules set forth in subsection D of this Section, the benefits of another Health Care Plan that contains a provision coordinating its benefits with the Plan before the benefits of the Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Plan.

D. Rules establishing the order of benefit determination as to a Participant's claim for the purposes of subsection C of this Section are as follows:

1. The benefits of a plan that covers the person other than as a Dependent shall be determined before the benefits of a plan that covers the person as a Dependent.

2. The benefits of a plan that covers the person as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year shall be determined before the benefits of a plan that covers such person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other, or each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan that does not have the provisions of this paragraph shall determine the order of benefits. However, in the case of a person for whom claim is made as a Dependent child:

(i) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan that covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a plan that covers the child as a Dependent of the parent without custody.

(ii) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan that covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan that covers that child as a Dependent of the step-parent, and the benefits of a plan that covers that child as a Dependent of the step-parent will be determined before the benefits of a plan that covers the child as a Dependent of the parent without custody.

(iii) Notwithstanding subparagraphs (i) and (ii) of this paragraph, when the parents are divorced or separated and there is a court decree that would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan that covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a Dependent child.

3. When paragraphs 1 and 2 of this subsection do not establish an order of benefits determination, the benefits of a plan that has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan that has covered the person the shorter period of time, except that:

(i) the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee or as the Dependent of a laid-off or retired employee shall be determined after the benefits of any other plan covering the person as an employee other than a laid-off or retired employee or a Dependent of a laid-off or retired employee; and,

(ii) if either plan does not have a provision regarding laid-off or retired employees and, as a result, each plan determines its benefits after the other, then the provisions of subparagraph (i) of this paragraph do not apply.

E. If a Participant who has enrolled under the Plan is entitled to inpatient benefits under another contract or policy of insurance due to inpatient care that began while the Participant was enrolled under a previously held policy, the Administrator will pay, subject to Copayments under the Plan, the difference between entitlements under the Plan and entitlements under the other contract or policy of insurance.

F. Benefits that are provided directly through a specified provider of an employer shall in all

cases be provided before the benefits of the Plan.

F-1. Benefits available under any plan or policy of dental coverage or care shall in all cases be provided before the benefits of this Plan for dental-related services.

G. Services and benefits for military service connected disabilities to which a Participant is legally entitled and for which facilities are reasonably available, shall in all cases be provided before the benefits of this Plan.

H. For purposes of this provision, the Administrator may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision. Any Participant claiming benefits under the Plan must furnish to the Administrator all information deemed necessary by the Administrator to implement this provision.

I. None of the above rules as to coordination of benefits will serve as a barrier to the Participant first receiving direct health services to which the Participant may be entitled under the Plan except as specifically stated in paragraph G of this Section XI.

J. Whenever payments have been made by the Administrator with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Section XI, the Administrator shall have the right to recover the payment, to the extent of the excess, from among one or more of the following as the Administrator shall determine: any person or persons to, or for, or with respect to whom, the excess payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

K. Workers' Compensation

All sums payable for services provided pursuant to workers' compensation shall not be reimbursable under the Plan.

L. Participant's Cooperation (Medicare)

Each Participant shall complete and submit to the Administrator such consents, releases, assignments and other documents as may be requested by the Administrator in order to obtain or assure reimbursement under Medicare. Any Medicare-eligible Participant who fails to enroll under Part B and, if eligible, Part A of the Medicare program, will be liable for the amount of benefits that Medicare would have covered had Participant so enrolled.

M. Facility of Payment

Whenever payments that should have been made under the Plan have been made under any other Health Care Plan, the Administrator shall have the right, exercisable in its sole discretion, to pay over to an organization making other payments any amounts it shall determine to be warranted in order to satisfy the intent of this Section XI. Amounts so paid by the Administrator shall be deemed to be benefits paid under the Plan, and to the extent of that payment, the Plan Sponsor and Administrator shall be fully discharged from liability under this Plan.

Disclosure

Each Participant agrees to disclose to the Administrator at the time of enrollment, at the time of receipt of services and benefits, and from time to time as requested by the Administrator, his Social Security number, birth date, employment status, and existence of other Health Care Plan coverage, in regard to which the identity of the carrier and the group through whom provided will be furnished by the Participant.

Administrator and Plan Sponsor understand that it may not be practicable to literally administer the provisions of this Article XI in certain circumstances where Medicare is the primary form of coverage for a claim and the plans to be administered herein are secondary. Consistent with the provisions of this Article XI and the Administrator's claim processing system and capabilities,

If a Subscriber changes his Residence from a place that is within the Service Area to a place that is outside the Service Area, the change shall result in loss of eligibility for In-Area Coverage, and the Subscriber and his Dependents will be eligible only for Out-of-Area Coverage effective upon the first day of the month next following the relocation of the Residence.

3. Transfer into the Service Area

If a Subscriber changes his Residence from a place that is located outside the Service Area to a place that is within the Service Area, the change will result in loss of Out-of-Area Coverage, and the Subscriber and his Dependents will be eligible only for In-Area Coverage effective upon the first day of the month next following the relocation of the Residence.

4. Expansion of Service Area

If the Administrator expands the Service Area resulting in inclusion of a Subscriber's Residence, the Subscriber and his Dependents will lose eligibility for Out-of-Area Coverage and shall become eligible only for In-Area Coverage. The transition of coverage shall take place on the first day of the month next following the giving of notice by the Plan Sponsor to the Subscriber. The Plan Sponsor shall not give the notice until the Administrator has advised that its provider network is in place for the Service Area Expansion.

5. Reduction of Service Area

If the Administrator reduces the Service Area resulting in the exclusion of a Subscriber's Residence, the Subscriber and his Dependents will lose eligibility for In-Area Coverage and become eligible only for Out-of-Area Coverage. The transition of coverage shall take place on the first day of the month next following the giving of notice by the Plan Sponsor to the Subscriber.

6. Determination of Residency

The Plan Sponsor's Human Resources Director may establish regulations that are consistent with this Plan for the determination and reporting of residency. The Plan Sponsor may at any time request proof of residency of any Subscriber. If the Subscriber fails to provide requested proof within thirty (30) days or if the materials provided fail to resolve the issue, then the Plan Sponsor may suspend or limit benefits available to the Subscriber and his Dependents until the issue is resolved. The Plan Sponsor reserves the right to recover any benefits that are paid in error to any Participant because a Subscriber failed to disclose his actual Residence or failed to disclose a change of Residence. This right is cumulative of all other rights under the Plan and at law.

XIV. PARTICIPANT COMPLAINT RESOLUTION PROCEDURE

A. General

The Administrator shall investigate and endeavor to resolve any and all complaints received from Participants relating to matters within the duties of the Administrator. Any inquiries or complaints shall be made to the Administrator in writing addressed as set forth in Section XV.C of this Plan Document or by calling the Administrator at the telephone number set forth in this Plan Document, or at the then current address and phone number of the then current Administrator. On occasion, individual Participants may find that:

(i) They do not understand or agree with the policies, procedures or operations of the Administrator;

(ii) They are not satisfied with some part of their treatment by Participating Health Care Providers; or

(iii) They disagree with the Administrator's adjudication of a claim for Out-of-Network Services or Out-of-Area Services.

The Administrator shall endeavor to resolve any complaint as expeditiously as possible, preferably with the source of the dissatisfaction.

B. Purpose of Administrator's Procedure.

In order to enhance Participant satisfaction and to resolve any complaints that may occur, the Administrator shall make available to Participants its Participant Complaint Resolution Procedure. The objectives of this Procedure are:

(i) To provide a clear procedure for complaint resolution that is easily understood by Participants;

(ii) To facilitate an expeditious resolution of all complaints;

(iii) To acquire feedback so that any recurring problems may be corrected; and

(iv) To provide management information so that Participant satisfaction may be measured and compared to the Administrator's service standards.

C. Communication with Participating Health Care Providers

Where applicable to In-Network Services, Participants are encouraged to communicate any question or concern directly to the Participating Physician, Health Care Provider or staff member rendering service in order to immediately resolve the issue.

D. Administrator's Participant Complaint Resolution Procedure

Specifically, the Participant Complaint Resolution Procedure involves the following:

1. **Definitions.**

a. An "inquiry" is a Participant's request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided. Administrator encourages Participants to resolve an individual inquiry without the initiation of a Complaint review.

b. An "Adverse Determination" is a determination that a service or supply is not Medically Necessary or appropriate.

c. A "Complaint" is any dissatisfaction expressed by a Participant orally or in writing to Administrator with any aspect of Administrator's operation, including but not limited to:

1. dissatisfaction with plan administration;

2. procedures related to review or appeal of an Adverse Determination;

3. the denial, reduction, or termination of a service for reasons <u>not</u> related to the services being Medically Necessary;

4. the way a service is provided;or

5. disenrollment decisions.

A Complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Participant.

A Complaint does not include a Provider's or Participant's dissatisfaction or disagreement with an Adverse Determination.

2. **Complaint Review.**

a. Administrator will send the Participant acknowledgment of the Complaint within 5 business days of having received it. The acknowledgment will contain:

1. the date of receipt of the Complaint;

2. a description of Administrator's Complaint procedures and deadlines;

3. a one-page Complaint form, clearly stating that the Complaint form must be returned to Administrator for prompt resolution of the Complaint, if the Complaint is received orally;

4. requests for the Participant to provide any additional information, including documentation, necessary to assist Administrator in handling and deciding the Complaint; and

5. a notice informing the Participant of the Participant's right to have an uninvolved Administrator representative assist the Participant in understanding the Complaint process.

Administrator will acknowledge, investigate, and resolve the Complaints within 30 calendar days from the date of receipt of the written Complaint or one-page Complaint form.

b. The Complaint Panel reviewing the Complaint shall be comprised of one or more employees of Administrator. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the Complaint.

c. A written notice stating the result of the review by the Complaint Panel shall be forwarded by Administrator to the Participant. Such notice shall include:

1. a description of the Panel's understanding of the Participant's Complaint as presented to the Complaint Panel (e.g., dollar amount of the disputed issue, medical facts in dispute, etc.); and

2. the Panel's decision in clear terms, including the contract basis or rationale, as applicable, in sufficient detail for the Participant to respond further to Administrator's position (e.g., the services were non-emergency services as identified in the medical report, the services were not covered by the Plan, etc.); and

3. citations to the evidence or documentation used as the basis for the decision, including the specialization of any Physician or Health Care Provider consulted (e.g., reference to the Plan, medical records, etc.);

4. that the decision of the Complaint Panel shall be final and binding unless appealed by the Participant to Administrator within 60 days of the date of the notice of the decision of the Complaint Panel; and

5. a full description of the Complaint appeals process and the deadlines for the final decision on the appeal.

3. **Complaint Appeals.**

a. Upon receipt of a Participant's written appeal of a Complaint, Administrator shall provide the Participant with an acknowledgment letter within 5 business days. This letter shall contain the procedures governing appeals before the Appeal Panel including the date and location for the Participant to appear before the Appeal Panel. The appeal process gives the Participant the opportunity to appear in person or by telephone before the Appeal Panel or address the Participant's issues through a written appeal to the Appeal Panel. The Participant shall be notified of the Participant's right to have an uninvolved Administrator representative available to assist the Participant in understanding the appeal process.

No less than 5 business days prior to the Participant's appearing before the Appeal Panel, the Participant will receive a copy of any documentation to be presented by the Administrator staff; the specialization of Physicians or Health Care Providers consulted during the review; and the name and affiliation of all Administrator representatives on the Appeal Panel. The Participant may respond to this information for the Appeal Panel to consider in the Administrator's deliberations.

b. The Appeal Panel shall be comprised of three Subscribers designated by Plan Sponsor, one of which designees will be a member of an employee union or similar organization; three Administrator staff persons not previously involved in the disputed decision; and three Physicians or Health Care Providers, at least one of whom shall be experienced in the area of care that is in dispute, who are independent of the Physicians or Health Care Providers who made the prior decision that resulted in the Participant's appeal. If specialty care is in dispute, the appeal panel shall include a person who is a specialist in the field of care to which the appeal relates.

c. The Appeal Panel shall hold appeal hearings within the Participant's county of residence or the county where the Participant normally receives health care services under the Plan. Another location may be used if agreed to by the Participant and Administrator.

d. The Participant shall have the right to attend the appeal hearing in person or by telephone and present their case, question the representative of Administrator designated to appear at the hearing and any other witnesses, including any person responsible for making the prior determination that resulted in the appeal. The Participant shall also have the right to be assisted or represented by a person of the Participant's choice, and to submit written material in support of their Complaint. The Participant may bring a Physician or other expert(s) to testify on the Participant's behalf. Administrator shall also have the right to present witnesses. Counsel for the Participant may present the Participant's case and question witnesses; if the Participant is so represented, Administrator may be similarly represented by counsel. The Appeal Panel shall have the right to question the Administrator representative, the Participant and any other witnesses.

e. The appeal hearing shall be informal. The Appeal Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Panel shall have the right to exclude redundant testimony or excessive argument by any party or witness.

f. A written record of the appeal hearing shall be made.

g. Before the record is closed, the Chair of the Appeal Panel shall ask both the Participant and the Administrator representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Panel. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Appeal Panel shall be confidential and shall not be transcribed.

h. The Appeal Panel shall render a written decision, which shall be advisory, within thirty (30) days of the conclusion of the appeal hearing. The decision shall contain:

1. date of receipt of the oral or written request for appeal;

2. a statement of the Appeal Panel's understanding of the nature of the Complaint and the material facts related thereto;

3. the Appeal Panel's decision and rationale, including a statement of the specific determination, clinical basis, and contractual criteria used to reach the final decision; and

4. a summary of the evidence, including necessary documents supporting the decision.

E. Appeals of Other Matters

The foregoing provisions relate to the provision of In-Network Services, claims processing disputes and other matters that are within the duties of the Administrator. The Plan Sponsor's Human Resources Director shall establish procedures and provide a hearing process for the resolution of disputes arising from actions of the Plan Sponsor including, without limitation, decisions concerning eligibility for participation in the Plan, effective dates of coverage and residency of Subscribers. A copy of the procedures may be obtained by contacting the Plan Sponsor's Human Resources Director.

F. To the extent that any action or decision taken or administered by the Administrator is subject to an Appeal Process that is required to be conducted in a manner that is specified under State or federal law or regulations, then the Administrator shall ensure that any person affected by the action or decision who may have a right of appeal is afforded information regarding the applicable appeal procedure, and that appeal procedure shall supersede the other provisions of this Section.

XV. MISCELLANEOUS

A. Pronouns

Masculine pronouns used in this Plan Document shall include both masculine and feminine genders.

B. Records and Information

1. Information from medical records of Participants and information received from Health Care Providers incident to the Provider-patient relationship shall be kept confidential. The information, except as reasonably necessary in connection with the administration of this Plan Document, or as required by law, may not be disclosed without the written consent of Participants.

2. For the purposes of administering the Plan (including, without limitation, Section XI or XII hereof), the Administrator may, to the extent legally allowable and without further consent of or notice to any Participant, release to or obtain from any insurance company or other organization or person any information, with respect to any person, that the Administrator deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to the Administrator any information as may be necessary to implement Section XI or XII hereof.

3. The Application completed by Subscriber authorizes any Health Care Provider to make such records, photographs or information available to the Administrator as the Administrator may reasonably request on behalf of a Subscriber or his Dependents.

C. Notices

Any notice under this Plan Document may be given by United States Mail, postage prepaid, addressed as follows:

If to the current Administrator:

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
P.O. Box 660044
Dallas, Texas 75266-0044

and thereafter, to the name and address of the successor Administrator provided to Participants by the Plan Sponsor.

If to the Plan Sponsor:

City of Houston
Human Resources Director
611 Walker, Suite 4-A
Houston, Texas 77002

If to Participant:

The latest address provided by the Participant on forms actually delivered to the Administrator or by the Plan Sponsor.

D. Telephone

The telephone number of the Administrator is (866) 757-6875.

E. Assignment

The benefits to a Participant under this Plan Document are personal to the Participant and are not assignable or otherwise transferable, except as authorized by the Administrator to service providers.

F. Severability

The invalidity or unenforceability of any term or condition hereof shall in no way affect the validity or enforceability of any other term or provision hereof.

G. Incorporation by Reference

The Schedule of Benefits attached hereto forms a part of this Plan Document as if fully incorporated herein.

H. List of Providers of Services

From time to time, the Administrator will provide to the Plan Sponsor, for dissemination to Subscribers, information identifying Participating Health Care Providers.

I. Furnishing Information

Any person claiming or who may claim benefits under the Plan shall facilitate the access of or furnish to the Administrator any information as may be necessary to implement this Plan Document, and the Administrator may release or obtain such information as needed to implement the provisions of this Plan Document.

J. Independent Parties

1. The relationship between the Administrator and the Participating Health Care Providers is that of independent contractors. Participating Health Care Providers are not agents or employees of the Administrator nor is the Administrator an employee or agent of any Participating Health Care Provider. Health Care Providers shall maintain the Provider-patient relationship with Participants and shall be the only parties responsible to Participants for the services that they provide.

2. Neither the Plan Sponsor nor any Participant is the agent or representative of the Administrator, and neither shall be liable for any acts or omissions of the

Administrator, its agents or employees, any Health Care Provider, or any other entity with which the Administrator has made or hereafter shall make arrangements for the performance of services in connection with the Plan.

K. The provision of any services or the payment of any claim under any circumstances in which the recipient was not legally entitled to benefits hereunder shall not create any right of benefits hereunder. The Administrator and the Plan Sponsor retain all rights to recover therefor, including by way of example but not limitation, the right to seek recovery at law or in equity and the right (after notice and a right to be heard on the matter) of offset against any claim or amounts payable to the Subscriber who is the beneficiary of the services or payment. The right of offset shall not extend to any claims and amounts payable to the Subscriber under whose coverage the error arose.

L. Information contained in the medical records of Participants and information received from Physicians, surgeons, Hospitals or other Health Care Providers incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Participant except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by Administrator in connection with the administration of the Plan, or in the compiling of aggregate statistical data. Such information that is identifiable with an individual Participant may not be disclosed to Plan Sponsor, in connection with the conduct of appeals or otherwise, without the written consent of the affected Participant.

M. Administrator will not prohibit, attempt to prohibit or discourage any Physician or Health Care Provider from discussing or communicating to a Participant or a Participant's designee any information or opinions regarding the Participant's health care, any provisions of the Plan as it relates to the medical needs of the Participant or the fact that the Physician's or Health Care Provider's contract with the Administrator has terminated or that the Physician or Health Care Provider will no longer be providing services under the Plan.

N. If this Plan Document contains any provision not in conformity with Texas State law or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

O. BlueCard Program

Administrator hereby informs Participants that other Blue Cross and Blue Shield Plans outside of Texas ("Host Blue") may have contracts with certain Providers ("Host Blue Providers") in their service area similar to the contracts between Administrator and Participating Providers. When a Participant receive health care services through the BlueCard Program outside of Texas and from a Host Blue Provider which does not have a contract with Administrator, the amount Participant pays for Covered Services is calculated on the lower of: The billed charges for Participant's Covered Services, or the negotiated price that the Host Blue passes on to Administrator. Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount Participant pays is considered a final price. Statutes in a small number of states may require the Host Blue to use a basis for calculating Participant liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Participant liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Administrator would then calculate Participant liability for any Covered Services in accordance with the applicable state statute in effect at the time Participant received care.

P. The Plan Administrator understands that the Plan has from time to time offered one or more

federally sponsored Medicare Advantage Plans to its Medicare eligible Retirees. If the Plan contracts with one or more providers of such Medicare Advantage plans, then the Plan shall allow eligible Participants to elect coverage there under rather than through this Plan in connection with initial enrollments or annual enrollment periods. Additionally, if the Plan's Eligible Retirees have enrolled in any such Medicare Advantage plan and the Medicare Advantage plan ceases operations or withdraws from the Houston market, then the Plan shall allow the affected Participants to enroll in this Plan. Furthermore, if any of the Plan's Eligible Retirees enroll in any Medicare Advantage plan offered by the Plan and then becomes dissatisfied with such coverage, then the Eligible Retiree shall be allowed to return to this Plan on the first day of each month. To the extent of any difference, these provisions will be recognized as exceptions to the eligibility requirements under this Plan.

SCHEDULE OF BENEFITS

CITY OF HOUSTON

PPO Health Program

This document, known as the "Schedule of Benefits," describes the benefits available to Participants in the City of Houston's PPO Health Program. The current Administrator for this Plan is Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation. This Schedule of Benefits is a combined description of the Plan's components including In-Network Services, Out-of-Network Services and Out-of-Area Services. It is important that the information contained in this Schedule of Benefits be carefully reviewed because all Plan provisions do not apply to all components of the Plan. Many aspects of the Plan are addressed in much greater detail in the Plan Document adopted by the City Council, which also governs benefits and services. Many of the capitalized terms in this Schedule of Benefits are defined in the Plan Document or in this Schedule of Benefits.

The Plan affords two categories of coverage. The availability of coverage is dependent upon the Residence of the Subscriber (Employee, Deferred Retiree, Retiree, Survivor) in relation to the Service Area. Subscribers who reside within the Service Area and their Dependents are entitled to In-Area Coverage, which consists of In-Network Services and Out-of-Network Services, but not to Out-of-Area Coverage. Subscribers who Reside outside the Service Area are entitled to Out-of-Area Coverage, but not to In-Area Coverage (In-Network Services and Out-of-Network Services). If a Subscriber moves his Residence into or out of the Service Area, then his coverage eligibility will change. If the Administrator expands or reduces the Service Area, then the coverage of the persons in the affected areas will also change.

Eligibility for participation in the Plan's components is as follows:

- **In-Network Services** - Employees, Deferred Retirees, Retirees and Survivors who Reside within the Service Area and their Dependents may elect to receive In-Network Services at the time that services are needed. In-Network Services provide a higher level of benefits available under the Plan.

- **Out-of-Network Services** - Employees, Deferred Retirees, Retirees and Survivors who reside within the Service Area and their Dependents may elect to receive Out-of-Network Services at the time that services are needed. Out-of-Network Services provide a lower level of benefits than are provided for In-Network Services.

- **Out-of-Area Services** - Employees, Deferred Retirees, Retirees and Survivors who reside outside the Service Area and their Dependents may receive Out-of-Area Services. These persons are *not* eligible to receive In-Network Services or Out-of-Network Services.

- **Dependents** - A Dependent is eligible to receive only the same benefits as the Employee, Deferred Retiree, Retiree or Survivor through whom he is enrolled, except as otherwise provided in **Section 1** of this Schedule of Benefits with respect to coverage under certain medical child support orders.

Plan Sponsor has from time to time offered one or more federally sponsored Medicare health maintenance organizations to its Medicare eligible Retirees. While Plan Sponsor does not presently have such an offering it intends to consider making such offerings available from time to time. If Plan Sponsor contracts with one or more providers of such Medicare health maintenance organizations, then: Administrator shall allow eligible Members to elect coverage there under rather than through this Plan in connection with initial enrollments or annual enrollment periods; additionally, if Plan Sponsor's Retirees have enrolled in any such Medicare health maintenance organization and the Medicare health maintenance organization ceases operations or withdraws from the Houston market, then Administrator shall allow the affected persons to enroll in this Plan. Furthermore, if a Retiree enrolls in any Medicare health maintenance organization offered by Plan Sponsor and then becomes dissatisfied with such coverage, then such Retiree shall be allowed to return to this Plan within ninety (90) days of such Retiree's enrollment of the Medicare health maintenance organization. To the extent of any difference, these provisions will be recognized as exceptions to the eligibility requirements under this Plan. You will find the following sections in this Schedule of Benefits:

SECTION 1: **Requirements For Health Care Services.** This section describes the general requirements that apply to health care services covered under the Plan.

SECTION 2: **What Is Covered.** This section describes which health care services are covered under the Plan, along with any limits on coverage for specific services. **Section 2** also provides the amounts (if any) to be paid by Participants at the time services are received.

SECTION 3: **What Is Not Covered.** This section describes health care services that are not covered under the Plan.

SECTION 1 - Requirements For Health Care Services

To be covered under the Plan, health care services must meet *all* of the applicable requirements described in **Section 1**.

A. Medical Necessity

The service must be *Medically Necessary*. To be "Medically Necessary," the service must meet *all* of the following conditions:

- The service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;
- If a Participant is ill or injured, the service is needed in order to keep the Participant's condition from getting worse;
- The service is generally accepted as safe and effective under standard medical practice in the community;
- The service is not primarily for the convenience of the Participant, his Physician, or Health Care Provider; and
- The service is provided in the most cost-efficient way, while still giving an appropriate level of care.

Not every service that fits this definition is covered under the Plan. To be covered, a service that is Medically Necessary must also be included in **Section 2** of this Schedule of Benefits, **What Is Covered**. For instance, the Plan does not cover any preventive, family planning or infertility services that are not specified in **Section 2**. Just because a Health Care Provider has performed, prescribed or recommended a service does not mean it is Medically Necessary or that it is covered under the Plan. (See also **Section 3** of this Schedule of Benefits, **What Is Not Covered**.)

B. Emergency Care; Urgent Care

In some provisions of the Plan, a distinction is made between *Emergency Care* and *Urgent Care*, as compared to other types of care. "Emergency Care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

(1) Placing the patient's health in serious jeopardy,
(2) Serious impairment to bodily functions,
(3) Serious dysfunction of any bodily organ or part,
(4) Serious disfigurement, or
(5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care includes the following services:

- An initial medical screening examination by the facility providing the Emergency Care or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists,
- Services for the treatment and stabilization of an emergency condition, and
- Post-stabilization care originating in a hospital emergency room or comparable facility, if authorized by the Administrator, provided that the Administrator must authorize or deny coverage within one hour of a request for authorization by the treating physician or the hospital emergency room.

"Urgent Care" means care for an urgent medical condition of sudden onset that is not serious enough to require Emergency Care, as defined above. The Administrator has also contracted with other Health Care Providers to provide extended hours Urgent Care, as Participating Health Care Providers for In-Network Services.

Emergency Care and Urgent Care benefits are limited to services that are obtained immediately after the emergency or urgent condition occurs, or as soon as possible thereafter. The Participant must seek treatment within 48 hours after the first appearance of the symptoms of an illness or after an accident. As soon as possible after the emergency or urgent condition occurs, the Participant (or someone acting for the Participant) must contact their Physician for advice and instructions. This contact must be made within 48 hours, unless it is impossible to do so.

Benefits for In-Network Services are not available for Urgent Care provided by Non-Participating providers, under any circumstances. In-Network Services are available for Emergency Care from Non-Participating providers. However, in order to retain benefits for In-Network Services, Participants who initially seek Emergency Care from Non-Participating providers must be transferred to the care of Participating providers as soon as this can be done without harming the Participant's condition. Covered Services provided by Non-Participating providers after the point at which the Participant can be safely transferred to the care of a Participating provider will be treated by the Plan as Out-of-Network Services.

The Administrator has the right to review all In-Network Services that are provided to Participants to determine that the conditions for Emergency Care have been met. If the Administrator determines that the services as provided did not satisfy one or more of these conditions, services other than the initial screening to determine whether an emergency medical condition exists will be treated as Out-of-Network Services.

C. In-Network Services

Participating Providers. The service must be provided by a Participating Health Care Provider. The Health Care Provider must be a Participating Provider at the time the service is rendered. All other Health Care Providers are considered to be "Non-Participating."

There are exceptions to the requirement that Participants desiring "In-Network" benefits get all covered health care services from Participating Health Care Providers:

- Care covered under **Emergency Care** provisions.
- Covered Services that cannot be provided by any Participating Health Care Provider. However, for these services the Administrator must preauthorizepre-authorize the referral to a Non-Participating Health Care Provider. The Administrator shall not deny a request for such a referral without the review and concurrence of a specialist of the same specialty or a similar specialty as the type of physician or provider to whom the referral is requested.

Some services require the Administrator's preauthorizationpre-authorization. **Section 2, What Is Covered,** indicates whether the Administrator's preauthorizationpre-authorization is required for most types of services.

BlueCard® Program and BlueCard Worldwide®. Participants with In-Area Coverage living or traveling in the Service Area but outside of Texas can receive In-Network Services from Participating Health Care Providers through the BlueCard Program, which provides access to more than 600,000 Physicians and more than 6,000 Hospitals. Participants may locate Participating Health Care Providers through the BlueCard Program by accessing the BlueCard Doctor and Hospital Finder at www.bcbs.com or by contacting Administrator. Participants must comply with any preauthorizationpre-authorization requirements under the Plan.

Participants with In-Area Coverage who are traveling outside of the United States may have access to Physicians and Hospitals in more than 200 countries around the world through BlueCard Worldwide. BlueCard Worldwide provides Participants with medical assistance services and access to Physicians and Hospitals around the world. If a Participant needs to locate a Physician or Hospital or need

medical assistance when outside the United States, the Participant may call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, along with a medical professional, will provide information on Physicians and Hospitals in the area where the Participant is traveling, and arrange a Physician appointment or hospitalization, if necessary. Participants should also call Administrator for pre-authorization, if necessary.

D. **Continuity of Coverage**

If a Participant is under the care of a Participating Health Care Provider at the time the Health Care Provider stops Participating in the managed care network, the Administrator will continue providing coverage for that Health Care Provider's services, even though he or she is no longer a Participating Health Care Provider, if all the following conditions are met:

- The Participant has a disability, acute condition or life-threatening illness; or
- The Participant is past the 13th week of pregnancy; and
- The Health Care Provider submits a written request to the Administrator for continued coverage of the Participant's care. The request must (a) identify the condition for which the Participant is being treated and (b) indicate that the Health Care Provider reasonably believes that discontinuing his or her treatment of the Participant could cause harm to the Participant; and
- The Health Care Provider agrees to continue accepting the same rate of reimbursement which applied when he or she was still a Participating Health Care Provider, and agrees not to seek payment from the Participant for any amounts for which the Participant would not be responsible if the Health Care Provider were still Participating.

The continuity of coverage available under this section shall not extend for more than ninety (90) days (or 9 months for terminal illness) beyond the date the Health Care Provider's termination takes effect, except that for Participants who are past the 13th week of pregnancy at the time the Health Care Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care and the follow-up check-up within the first six weeks of delivery.

E. **Out-of-Network Services**

The Plan provides Employees, Deferred Retirees, Retirees and Survivors who Reside within the Service Area and their Dependents with the option of obtaining services from Non-Participating Health Care Providers. This option is provided by the Out-of-Network Services component of the Plan. In these cases, the level of benefits for which the Participant is eligible is usually less than those benefits available in the In-Network Services component of the Plan. In-Network Services and Out-of-Network Services levels are described in **Section 2, What is Covered.**

The Administrator must preauthorize certain benefits provided in the Out-of-Network of Participating Health Care Providers Services component of the Plan. All benefits received in the Out-of-Network Services component of the Plan must be Medically Necessary and all of the Plan's limitations and exclusions apply to this component of the Plan.

Out-of-Network Services should not be confused with Out-of-Area Services, which are described below. Employees, Deferred Retirees, Retirees and Survivors who Reside within the Service Area and their Dependents are not entitled to Out-of-Area Services. Out-of-Network Services will apply to all Covered Services that they receive from Non-Participating Health Care Providers, regardless of whether the providers' services are rendered inside or outside the Service Area. See above for special provisions regarding Emergency Care on an In-Network Services basis.

When seeking Out-of-Network Services, Participants may choose to utilize ParPlan Providers to provide such services. If a Participant uses a ParPlan Provider for Out-of-Network Services, the ParPlan Provider will: (1) file all claims for Participant; (2) accept the Administrator's Usual and Customary Charges as payment for Medically Necessary Covered Services; and (3) not bill Participant for Covered Services over the Usual and Customary Charge determination. Participant will be responsible for any applicable Deductibles, Coinsurance, or services that are not Covered Services.

F. **Out-of-Area Services**

The Plan contains separate provisions that are available exclusively to Employees, Deferred Retirees, Retirees and Survivors who Rreside outside the Service Area and to their Dependents. Those persons are not entitled to receive benefits for In-Network Services, even if they should elect to use a Participating Health Care Provider, or for Out-of-Network Services. However, they are entitled to indemnity-type benefits that are generally greater than those extended for Out-of-Network Services to Participants who Reside within the Service Area.

The Administrator must preauthorizepre-authorize certain benefits provided as Out-of-Area Services. All services received in the Out-of-Area Services component of the Plan must be Medically Necessary, and all Plan limitations and exclusions apply to this portion of the Plan.

The network of Participating Health Care Providers established by the Administrator for In-Network Services includes numerous Participating providers that may also be utilized for care by persons who hold Out-of-Area Coverage. However, benefits at the higher In-Network Services level are available only to Participants who hold In-Area Coverage. Persons who hold Out-of-Area Coverage are not entitled to benefits at the higher In-Network Service levels, even if they use Participating Health Care Providers, except as provided for prescription drugs.

When seeking Out-of-Area Services, Participants may choose to utilize ParPlan Providers to provide such services. If a Participant uses a ParPlan Provider for Out-of-Area Services, the ParPlan Provider will: (1) file all claims for Participant; (2) accept the Administrator's Usual and Customary Charges as payment for Medically Necessary Covered Services; and (3) not bill Participant for Covered Services over the Usual and Customary Charge determination. Participant will be responsible for any applicable Deductibles, Coinsurance, or services that are not Covered Services.

G. **Medical Child Support Order Coverage**

The provisions of this section shall apply to coverage of children that is provided in compliance with a medical support order of a court or other authority. If the covered child physically lives within the Service Area, then the child shall be entitled to the same benefits as other Participants who reside in the Service Area. If the covered child does not physically live within the Service Area, then the child shall be entitled to the same coverage to which the Subscriber who is responsible for the child's coverage is entitled or, notwithstanding the place of residence of the Subscriber who is responsible for the child's coverage, be entitled to elect the "Out-of-Area Coverage" provisions of this Plan. To the extent required for compliance with applicable state and federal laws and regulations, the Administrator may also develop and implement alternative service delivery strategies to ensure the coverage provided complies with applicable legal requirements.

H. **Other Restrictions**

In addition to the general requirements described above, there are specific restrictions on coverage for some services. For instance, some services are only covered if preauthorizepre-authorized by the Administrator. Eligible expenses appear in **Section 2, What is Covered** and mean the Usual and Customary Charge for an item of care at least part of which is covered by the Plan. There are also time limits on coverage for some services. These restrictions are described in **Section 2, What is Covered.**

I. **Plan Features**

The Plan is characterized by a distinct network of Participating Health Care Providers, Service Area, and Deductibles, Copayments and Coinsurance. This part describes how the Deductibles, Copayments and Coinsurance apply.

With exceptions for certain Covered Services for which only a Copayment is payable, as explained in **Section 2**, the Plan has an annual Deductible amount that must be met before benefits are provided for any Covered Services. Following the satisfaction of the Deductible amount, the Plan **generally** provides benefits on a co-insured basis with the Participant's benefit being 80% for In-Network and

Out-of-Area Covered Services and 60% for Out-of-Network Covered Services, and the Participant being responsible for the remaining Coinsurance balance of 20% or 40%, as applicable. The Plan also features both individual and family Annual Combined Coinsurance/Deductible Maximum Amounts ("Annual Maximum"). The Annual Maximum aggregates the Deductible, Coinsurance and Copayment amounts payable by the individual Participant or family. When the Annual Maximum amount is reached, the Participant or family is excused from further Coinsurance and Deductible obligations for services incurred during the balance of the Calendar Year, but will remain obligated to satisfy any Copayment amounts.

The following additional rules and considerations apply:

1. The Plan provides benefits only for Covered Services as articulated in **Sections 2 and 3**. Additionally, only expenses for Covered Services will be applied to Deductibles, Copayments and Annual Maximum amounts.

2. The Plan operates on a Calendar Year basis (January 1 through December 31). For purposes of computing Deductibles, Copayments and the Annual Maximums, expenses are attributable to the year in which they are rendered, even if the Provider invoices for the services in the following Calendar Year. Expenses and benefits for inpatient services that commence in one Calendar Year and end in the next are attributable in the Calendar Year in which the admission commenced.

3. With respect to the Deductible and the Annual Maximum, the Plan features computation on both an individual basis and a family basis. Family computations are based upon expenditures incurred by the Subscriber and his covered Dependents. When the annual family Deductible has been met, each person in the family is deemed to have satisfied his Deductible for the balance of that Calendar Year. When the family Annual Maximum has been met, each person in the family is deemed to have satisfied his Annual Maximum for the balance of that Calendar Year. Only amounts that are applied to an individual Participant's Deductible or Annual Maximum may be also applied to the family's Deductible or Annual Maximum and no individual can contribute more than his/her own annual Deductible and Annual Maximum to the family annual Deductible and Annual Maximum.

4. Both Annual Maximums and Deductibles will be computed on a Calendar Year basis. However, the Plan features a 4th Quarter Carryover Provision that applies to Deductibles but not to any other components of the Annual Maximum amounts. Amounts that are applied to or could have been applied to the actual satisfaction of a Deductible in the 4th quarter of a Calendar Year (October 1 through December 31) carry forward to the following Calendar Year. If the Participant or Subscriber family group has not met the annual Deductible for Covered Services incurred on or by September 30th of any Calendar Year, then this benefit is available without regard to whether the Participant or Subscriber family group meets the Deductible with Covered Services in the 4th quarter.

5. Different Deductible amounts and Annual Maximums apply to In-Network versus Out-of-Network Covered Services for Participants who hold In-Area Coverage. A separate annual accounting will be maintained for the In-Network and Out-of-Network Deductible and Annual Maximum balances. The Out-of-Network balances also attribute to the In-Network balances, but the In-Network balances do not attribute to the Out-of-Network balances. This provision has no application to Participants who have Out-of-Area Coverage.

6. The Plan requires Participants to make Copayments for many types of Covered Services. The Copayment amount is always payable, even after the Annual Maximum has been met, and additional Copayments made for a Participant who has reached the individual Annual Maximum will not attribute to his/her family's Annual Maximum.

7. Certain Covered In-Network Services for Participants who have In-Area Coverage, such as some outpatient services, are available without having first met the annual Deductible. See **Section 2**.

8. The Plan requires benefits for certain Covered Services to be pre-authorized by the Administrator and in some instances imposes an additional Copayment for failure to comply with that requirement; any such additional Copayment does not apply to the Annual Maximum amount.

9. The pharmacy benefit functions as a wholly separate program. No pharmacy benefit expenditure has any bearing as benefits provided for other Covered Services regardless of the satisfaction of the above-described Deductible or Annual Maximums for any other Covered Services. Pharmacy expenses do not apply to Deductibles and Annual Maximums.

10. Except as provided in items 8 and 9, above, for additional failure to pre-authorize Copayments and pharmacy Copayments, all types of Copayments apply to Annual Maximum amounts.

J. Relocation of Subscribers' Residences

As explained in the preamble of this Schedule of Benefits, the Plan provides different benefits for Subscribers who reside in the Administrator's Service Area and their Covered Dependents versus Subscribers who do not reside in the Administrator's Service Area and their Covered Dependents. Any Subscriber who relocates his residence should notify the City of Houston Human Resources Department and will be advised whether the relocation affects the type of coverage that the Subscriber and his Covered Dependents will thereafter receive. At the time of drafting of this Schedule of Benefits, the Administrator and its affiliated organizations have a Service Area that includes all or part of every state within the United States, except Montana.

In the event that a Subscriber relocates his residence from a place outside the Service Area to a place that is inside the Service Area, then the annual accruals of the Subscriber and his Covered Dependents for Deductibles and Annual Maximums for Out-of-Area Services prior to the relocation will be regarded as though they had been expended for Out-of-Network Services, which as explained in Item I, above, means they will also be attributable to In-Network Services.

In the event that a Subscriber relocates his residence from a place inside the Service Area to a place that is outside the Service Area, then the annual accruals of the Subscriber and his Covered Dependents for Deductibles and Annual Maximums for both In-Network Services and Out-of-Network Services prior to the relocation will be combined and regarded as though they had been expended for Out-of-Area Services.

K. Administrator Review

The Administrator has the right to monitor any health care services received to make sure they are being provided in the most efficient manner that is medically appropriate. In making any decision about health care services under the Plan, the Administrator may consult with any health care professional or organization that it deems to be helpful, if permitted by law. The Administrator also has the right to have health care professionals of its choice examine Participants' medical records and physical condition, if permitted by law. The Administrator uses this information to assist in the coordination of Covered Services (such as planning for care after discharge from the hospital), to help decide whether to preauthorizepre-authorize services, or to make other decisions about coverage under the Plan.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
Plan Coverage percentage (unless specified otherwise). The remaining percentage is the Participant's Coinsurance, which is waived after Annual Maximum is reached. Out-of-Network Coinsurance applies to In-network, but In-Network does not apply to Out-of-Network. Refer to Section 1 for more detail.	80%	60%	80%
Annual Plan Deductible Amounts. Out-of-Network Deductible applies to In-network, but In-network does not apply to Out-of-Network. Refer to Section 1 for more detail. Individual Deductible Family Deductible	 $200 $600	 $ 400 $1,200	 $ 350 $1,050
4th Quarter Carryover Deductible	Yes	Yes	Yes
Annual Maximum Amounts Refer to Section 1 for more detail. Individual Family	 $3,000 $6,000	 $ 5,000 $10,000	 $3,000 $6,000

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
Hospital Inpatient Copayment	**$500.00** per confinement and eligible Hospital expenses are covered at **80%** thereafter. For obstetrical patients, Copayment is payable for the mother with no additional Copayment for the baby or babies, unless re-admitted because it is Medically Necessary. Copayment is waived for transfers or for readmission to the Hospital or other facility for the same illness or injury within 5 days of time of prior release from Hospital.	**$1,000.00** per confinement and eligible Hospital expenses are covered at **60%** thereafter. For obstetrical patients, Copayment is payable for the mother, with no additional Copayment for the baby or babies, unless re-admitted because it is Medically Necessary. Copayment is waived for transfers or for readmission to the Hospital or facility for the same illness or injury within 5 days of time of prior release from Hospital. Failure to receive **pre-authorization** will result in an additional **$250.00** Copayment per Hospital confinement that is in addition to the Hospital Inpatient Copayment	**$250.00** per confinement and eligible Hospital expenses are covered at **80%** thereafter. For obstetrical patients, Copayment is payable for the mother, with no additional Copayment for the baby or babies, unless re-admitted because it is Medically Necessary. Copayment is waived for transfers or for readmission to the Hospital or facility for the same illness or injury within 5 days of time of prior release from Hospital. Failure to receive **pre-authorization** will result in an additional **$250.00** Copayment per Hospital confinement that is in addition to the Hospital Inpatient Copayment
Physician Office Visit (Includes illness, injury and routine preventive care for adults and children)	Eligible expenses covered at **100%** after **applicable** Copayment per visit Copayment amounts are: Primary Physician -$30.00 Specialist -$50.00	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Laboratory services	Eligible expenses covered at **100%** when associated with a Physician Office Visit.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Radiology/Imaging Services	Eligible expenses covered at **100%** when associated with a PhysicianOffice Visit.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Surgical procedures in Physician's office	Eligible expenses covered at **80%** after Plan Deductible is met.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OUTPATIENT SERVICES			
Medications and materials administered or applied in Physician's office	Eligible expenses covered at **100%** (after **applicable** Physician Office Visit Copayment). Medications administered orally, by injection or otherwise; biologicals, fluids, radioactive materials and inhalation therapy; and dressings, casts and splints (where commonly used instead of casts) are covered when administered or applied in the Physician's office. Administration of these medications and materials is not covered if they are or could be administered or applied in the home by someone who is not a Physician.	Eligible expenses covered at **60%** after Plan Deductible is met. Medications administered orally, by injection or otherwise; biologicals, fluids, radioactive materials and inhalation therapy; and dressings, casts and splints (where commonly used instead of casts) are covered when administered or applied in the Physician's office. Administration of these medications and materials is not covered if they are or could be administered or applied in the home by someone who is not a Physician.	Eligible expenses covered at **80%** after Plan Deductible is met. Medications administered orally, by injection or otherwise; biologicals, fluids, radioactive materials and inhalation therapy; and dressings, casts and splints (where commonly used instead of casts) are covered when administered or applied in the Physician's office. Administration of these medications and materials is not covered if they are or could be administered or applied in the home by someone who is not a Physician.
Chemotherapy	Eligible expenses covered at **80%** after **applicable** Physician Office Visit Copayment when performed in a Primary Physician's or a Specialist's office. Eligible expenses covered at **80%** after Plan Deductible is met in an outpatient setting.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Pre-natal and post-natal obstetrical care	Eligible expenses covered at **100%** after **$30.00** Copayment for the first visit. There is no Copayment for additional visits relating to the same pregnancy.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OUTPATIENT SERVICES (continued)			
Prescription Drugs, Retail – Thirty day Supply. (See **Section 3, What is Not Covered** for limitations on this benefit.) For any non mail order prescription that allows refills, these Copayments apply separately to the original filling and to each refilling of the prescription. Prescription drugs for smoking cessation are covered up to $185, limited to one course of treatment annually. Insulin, insulin analogs, insulin pens, syringes, needles, injection devices, glucagons kits, lancets, lancet devices, urine and blood test strips, and prescriptive and nonprescriptive oral agents for controlling blood sugar levels are covered.	**Participating Pharmacy** Covered in full after **$10.00** Copayment per prescription filled for generic prescription drugs, **$30.00** Copayment per prescription filled for Preferred brand name prescription drugs, and **$45.00** Copayment per prescription filled for Non-Preferred prescription drugs. Copayment for brand name prescription drugs when product selection is permitted by the Physician and a generic equivalent is available is the total of the generic Copayment plus the difference in cost between the brand name and bioequivalent generic products. **NOTE:** Actual prescription price to be paid if the prescription costs less than **$10.00, $30.00,** or **$45.00,** as applicable. **Non-Participating Pharmacy** Covered at **50%** after **$20.00** Copayment per prescription filled.	**Participating Pharmacy** Covered in full after **$10.00** Copayment per prescription filled for generic prescription drugs, **$30.00** Copayment per prescription filled for Preferred brand name prescription drugs, and **$45.00** Copayment per prescription filled for Non-Preferred prescription drugs. Copayment for brand name prescription drugs when product selection is permitted by the Physician and a generic equivalent is available is the total of the generic Copayment plus the difference in cost between the brand name and bioequivalent generic products. **NOTE:** Actual prescription price to be paid if the prescription costs less than **$10.00, $30.00,** or **$45.00,** as applicable. **Non-Participating Pharmacy** Covered at **50%**, after **$20.00** Copayment per prescription filled.	**Participating Pharmacy** Covered in full after **$10.00** Copayment per prescription filled for generic prescription drugs, **$30.00** Copayment per prescription filled for Preferred brand name prescription drugs, and **$45.00** Copayment per prescription filled for Non-Preferred prescription drugs. Copayment for brand name prescription drugs when product selection is permitted by the Physician and a generic equivalent is available is the total of the generic Copayment plus the difference in cost between the brand name and bioequivalent generic products. **NOTE:** Actual prescription price to be paid if the prescription costs less than **$10.00, $30.00,** or **$45.00,** as applicable. **Non-Participating Pharmacy** Covered at **50%**, after **$20.00** Copayment per prescription filled.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OUTPATIENT SERVICES (continued)			
Prescription Drugs – Mail Order (see **Section 3, What Is Not Covered** for limitations on this benefit.) For each Prescription that allows refills, these Copayments apply for each ninety (90) day supply for such Prescription. Prescriptions are limited to a maximum ninety (90) day supply of medication. Note: This benefit is available only through network pharmacies designated by the Administrator. Prescription Copayments do not apply to Annual Maximum Amounts. See **www.bcbstx.com** for a listing of the Preferred brand name drugs.	Covered in full after **$20.00** Copayment per prescription filled for generic prescription drugs, **$60.00** Copayment per prescription filled for Preferred brand name prescription drugs, and **$90.00** Copayment per prescription filled for Non-Preferred prescription drugs. Copayment for name brand prescription drugs when product selection is permitted by the Physician and a generic equivalent is available is the total of the generic Copayment plus the difference in cost between the brand name and bioequivalent generic. **NOTE:** Actual prescription price to be paid if the prescription costs less than **$20.00**, **$60.00** or **$90.00**, as applicable.	Covered in full after **$20.00** Copayment per prescription filled for generic prescription drugs, **$60.00** Copayment per prescription filled for Preferred brand name prescription drugs, and **$90.00** Copayment per prescription filled for Non-Preferred prescription drugs. Copayment for name brand prescription drugs when product selection is permitted by the Physician and a generic equivalent is available is the total of the generic Copayment plus the difference in cost between the brand name and bioequivalent generic. **NOTE:** Actual prescription price to be paid if the prescription costs less than **$20.00**, **$60.00** or **$90.00**, as applicable.	Covered in full after **$20.00** Copayment per prescription filled for generic prescription drugs, **$60.00** Copayment per prescription filled for Preferred brand name prescription drugs, and **$90.00** Copayment per prescription filled for Non-Preferred prescription drugs. Copayment for name brand prescription drugs when product selection is permitted by the Physician and a generic equivalent is available is the total of the generic Copayment plus the difference in cost between the brand name and bioequivalent generic. **NOTE:** Actual prescription price to be paid if the prescription costs less than **$20.00**, **$60.00** or **$90.00**, as applicable.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OUTPATIENT SERVICES (continued)			
Step Therapy Coverage for certain prescription drugs or drug classes is subject to a step therapy program. To ensure that a drug is Medically necessary and part of a specific treatment plan these prescription drugs or drug classes may require the utilization of acceptable alternative medication prior to these drugs or drug classes being covered. The list of drugs or drug classes subject to the step therapy program is determined by the Claims Administrator and may change from time to time If it is Medically Necessary, coverage can be obtained for the prescription drugs or drug classes subject to the step therapy program without trying an alternative medication first. In this case, the Participant's Physician must contact the Claims Administrator to obtain prior authorization for coverage of such drug. If prior authorization is approved, the participating Physician will be notified and the medication will then be covered at the applicable copay.	**Step Therapy** Coverage for certain prescription drugs or drug classes is subject to a step therapy program. To ensure that a drug is Medically necessary and part of a specific treatment plan these prescription drugs or drug classes may require the utilization of acceptable alternative medication prior to these drugs or drug classes being covered. The list of drugs or drug classes subject to the step therapy program is determined by the Claims Administrator and may change from time to time If it is Medically Necessary, coverage can be obtained for the prescription drugs or drug classes subject to the step therapy program without trying an alternative medication first. In this case, the Participant's Physician must contact the Claims Administrator to obtain prior authorization for coverage of such drug. If prior authorization is approved, the participating Physician will be notified and the medication will then be covered at the applicable copay.	**Step Therapy** Coverage for certain prescription drugs or drug classes is subject to a step therapy program. To ensure that a drug is Medically necessary and part of a specific treatment plan these prescription drugs or drug classes may require the utilization of acceptable alternative medication prior to these drugs or drug classes being covered. The list of drugs or drug classes subject to the step therapy program is determined by the Claims Administrator and may change from time to time If it is Medically Necessary, coverage can be obtained for the prescription drugs or drug classes subject to the step therapy program without trying an alternative medication first. In this case, the Participant's Physician must contact the Claims Administrator to obtain prior authorization for coverage of such drug. If prior authorization is approved, the participating Physician will be notified and the medication will then be covered at the applicable copay.	**Step Therapy** Coverage for certain prescription drugs or drug classes is subject to a step therapy program. To ensure that a drug is Medically necessary and part of a specific treatment plan these prescription drugs or drug classes may require the utilization of acceptable alternative medication prior to these drugs or drug classes being covered. The list of drugs or drug classes subject to the step therapy program is determined by the Claims Administrator and may change from time to time If it is Medically Necessary, coverage can be obtained for the prescription drugs or drug classes subject to the step therapy program without trying an alternative medication first. In this case, the Participant's Physician must contact the Claims Administrator to obtain prior authorization for coverage of such drug. If prior authorization is approved, the participating Physician will be notified and the medication will then be covered at the applicable copay.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OUTPATIENT SERVICES (continued)			
Rehabilitation, speech, hearing, occupational, and physical therapy; treatment for acquired brain injury	Eligible expenses covered at **80%** after **the applicable** Physician Office Visit Copayment when performed in a Physician's office. Eligible expenses covered at **80%** after Plan Deductible is met in an outpatient setting. Copayment per visit, under following condition: Attending Physician authorizes services as Medically Necessary. Coverage is limited to services that continue to meet or exceed treatment goals established for the Participant. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Coverage for treatment of acquired brain injury will be the same as for treatment for any other physical condition. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an acquired brain injury.	Eligible expenses covered at **60%** after Plan Deductible is met, under following conditions: Attending Physician authorizes the services as Medically Necessary. Coverage is limited to services that continue to meet or exceed treatment goals established for the Participant. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Coverage for treatment of acquired brain injury will be the same as for treatment for any other physical condition. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an acquired brain injury.	Eligible expenses covered at **80%** after Plan Deductible is met, under following conditions: Attending Physician authorizes the services as Medically Necessary. Coverage is limited to services that continue to meet or exceed treatment goals established for the Participant. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Coverage for treatment of acquired brain injury will be the same as for treatment for any other physical condition. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an acquired brain injury.
Body Distortion Services (See Section 3 for annual limit).	Eligible expenses covered at **80%** after **applicable** Copayment when performed in a Physician's office. Eligible expenses covered at **80%** after Plan Deductible is met in an outpatient setting.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OUTPATIENT SERVICES (continued)			
Outpatient Surgery (Except as otherwise specified in the document.)	Eligible expenses covered at **80%** after Plan Deductible is met. Includes invasive diagnostic procedures.	Eligible expenses covered at **60%** after Plan Deductible is met. Includes invasive diagnostic procedures.	Eligible expenses covered at **80%** after Plan Deductible is met. Includes invasive diagnostic procedures.
Primary Physician or Specialist services at home	Eligible expenses covered at **100%** after Copayment equivalent to applicable Physician Office Visit Copayment when Participant is medically unable to leave home and services cannot be performed by a non-Physician.	Eligible expenses covered at **60%** after Plan Deductible is met, when Participant is medically unable to leave home and services cannot be performed by a non-Physician.	Eligible expenses covered at **80%** after Plan Deductible is met, when Participant is medically unable to leave home and services cannot be performed by a non-Physician.
Home health care services	Skilled, non-custodial home health care services are covered at **80%** after Plan Deductible is met. These services must be **pre-authorized** by the Administrator. Limited to 60 visits per Calendar Year.	Skilled, non-custodial home health care services are covered at **60%** after Plan Deductible is met. These services must be **pre-authorized** by the Administrator. Limited to 60 visits per Calendar Year.	Skilled, non-custodial home health care services are covered at **80%** after Plan Deductible is met. These services must be **pre-authorized** by the Administrator. Limited to 60 visits per Calendar Year.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
PREVENTIVE SERVICES			
Check-ups	See Physician Office Visit	See Physician Office Visit	See Physician Office Visit
Well Baby and Well Child Care	See Physician Office Visit	See Physician Office Visit	See Physician Office Visit
Routine immunizations	Childhood immunizations covered at **100%** with no Copayment or Deductible through sixth birthday. After sixth birthday, eligible expenses covered at **100%** after **applicable Physician Office Visit** Copayment when recommended by the American Academy of Pediatrics and U.S. Public Health Service. Immunizations for travel outside the U.S., for employment, school sports, extracurricular activities or recreational activities are not covered. Copayment applies to other services provided at same time as immunizations.	Childhood immunizations covered at **100%** with no Copayment or Deductible through sixth birthday. After sixth birthday, eligible expenses covered at **60%** after Plan Deductible when recommended by the American Academy of Pediatrics and U.S. Public Health Service. Immunizations for travel outside the U.S., for employment, school sports, extracurricular activities or recreational activities are not covered. Copayment applies to other services provided at same time as immunizations.	Childhood immunizations covered at **100%** with no Copayment or Deductible through sixth birthday. After sixth birthday, eligible expenses covered at **80%** after Plan Deductible when recommended by the American Academy of Pediatrics and U.S. Public Health Service. Immunizations for travel outside the U.S., for employment, school sports, extracurricular activities or recreational activities are not covered. Copayment applies to other services provided at same time as immunizations.
Well-man examination including annual male diagnostic exam for prostate cancer including physical examination. Also includes a prostate specific antigen test for all Participants age 50 and over and for those persons age 40 with a family history of prostate cancer or other prostate cancer risk factor.	Eligible expenses covered at **100%**.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
PREVENTIVE SERVICES (continued)			
Medical rectal screening for the detection of colorectal cancer is covered for Participants 50 years of age or older for expenses incurred in conducting medically recognized diagnostic examinations for the detection of colorectal cancer. Such services include, but are not limited to, fecal occult blood test performed annually; a flexible sigmoidoscopy with hemoccult of the stool performed every 5 years; and a colonoscopy performed every 10 years.	Eligible expenses covered at **100%**	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Annual female breast cancer screening by mammography	Eligible expenses covered at **100%**	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Well-woman examinations/obstetrical/ gynecological treatment **Cervical Cancer Screening**	Eligible expenses covered at **100%**	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after plan deductible is met.
Osteoporosis Screening	Bone mass measurements to determine a Qualified Individual's risk of osteoporosis and fractures associated with osteoporosis are covered if the services are authorized by the Physician. Eligible expenses covered at **100%** after **applicable** Physician Office Visit Copayment	Bone mass measurements to determine a Qualified Individual's risk of osteoporosis and fractures associated with osteoporosis are covered if the services are authorized by the Physician. Eligible expenses covered at **60%** after Plan Deductible is met.	Bone mass measurements to determine a Qualified Individual's risk of osteoporosis and fractures associated with osteoporosis are covered if the services are authorized by the Physician. Eligible expenses covered at **80%** after Plan Deductible is met.

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SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
PREVENTIVE SERVICES (continued)			
Routine sight, speech and hearing screening for children	Eligible expenses covered at **100%** after **applicable** Copayment when performed as part of a Physician Office Visit for Participants under age 18. Exams for glasses, contact lenses, hearing aids, vision, hearing, speech, occupational or educational therapy are not covered.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Therapies for Children with Developmental Delays	Eligible expenses covered at **100%** after **applicable** Physician Office Visit. Benefits are available to a Dependent Child for the necessary rehabilitative and habilitative therapies in accordance with the individual family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code. Such therapies include: *occupational therapy evaluations and services; *physical therapy evaluations and services; *speech therapy evaluations and services; and * dietary or nutritional evaluations	Eligible expenses covered at **60%** after Plan Deductible is met. Benefits are available to a Dependent Child for the necessary rehabilitative and habilitative therapies in accordance with the individual family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code. Such therapies include: *occupational therapy evaluations and services; *physical therapy evaluations and services; *speech therapy evaluations and services; and * dietary or nutritional evaluations	Eligible expenses covered at **80%** after Plan Deductible is met. Benefits are available to a Dependent Child for the necessary rehabilitative and habilitative therapies in accordance with the individual family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code. Such therapies include: *occupational therapy evaluations and services; *physical therapy evaluations and services; *speech therapy evaluations and services; and * dietary or nutritional evaluations
Therapies for Children with Developmental Delays (continued)	The individual family service plan must be submitted to the Administrator prior to the commencement of services and when the individualized family service plan is altered. For purposes of this benefit provision, the following definitions will apply: Development delay means significant variation in normal development as measured by appropriate diagnostic instruments and	The individual family service plan must be submitted to the Administrator prior to the commencement of services and when the individualized family service plan is altered. For purposes of this benefit provision, the following definitions will apply: Development delay means significant variation in normal development as measured by appropriate diagnostic instruments and	The individual family service plan must be submitted to the Administrator prior to the commencement of services and when the individualized family service plan is altered. For purposes of this benefit provision, the following definitions will apply: Development delay means significant variation in normal development as measured by appropriate diagnostic instruments and

PPO 0074

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
PREVENTIVE SERVICES (continued)			
	procedures, in one or more of the following areas: cognitive development; physical development; communication development; social or emotional development; or adaptive development. Individualized family service plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention. After a child has reached the age of 3, services under the individualized family service plan are completed, and Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.	procedures, in one or more of the following areas: cognitive development; physical development; communication development; social or emotional development; or adaptive development. Individualized family service plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention. After a child has reached the age of 3, services under the individualized family service plan are completed, and Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.	procedures, in one or more of the following areas: cognitive development; physical development; communication development; social or emotional development; or adaptive development. Individualized family service plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention. After a child has reached the age of 3, services under the individualized family service plan are completed, and Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Outpatient mental health services (other than Serious Mental Illness)	Eligible expenses covered at **80%** after **applicable** Copayment. 30 visit maximum benefit per Calendar Year. Illness or disorder must be listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Physician must authorize and the Administrator must **pre-authorize** services.	Eligible expenses covered at **60%** after Plan Deductible, 30 visit maximum benefit per Calendar Year. Illness or disorder must be listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Physician must authorize and the Administrator must **pre-authorize** services.	Eligible expenses covered at **80%** after Plan Deductible. 30 visit maximum benefit per Calendar Year. Illness or disorder must be listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Physician must authorize and the Administrator must **pre-authorize** services.
Outpatient chemical dependency treatment	Eligible expenses covered at **80%** after **applicable** Copayment per visit. Lifetime maximum of 3 separate series of treatments per Participant as specified in accordance with Art. 3.51-9 of the Texas Insurance Code. Lifetime maximum will be computed to include inpatient and outpatient treatment under this Plan or any other City-sponsored plan, policy or HMO, whether currently or formerly offered.	Eligible expenses covered at **60%** after Plan Deductible is met. Lifetime maximum of 3 separate series of treatments per Participant as specified in accordance with Art. 3.51-9 of the Texas Insurance Code. Lifetime maximum will be computed to include inpatient and outpatient treatment under this Plan or any other City-sponsored plan, policy or HMO, whether currently or formerly offered.	Eligible expenses covered at **80%** after Plan Deductible is met. Lifetime maximum of 3 separate series of treatments per Participant as specified in accordance with Art. 3.51-9 of the Texas Insurance Code. Lifetime maximum will be computed to include inpatient and outpatient treatment under this Plan or any other City-sponsored plan, policy or HMO, whether currently or formerly offered.
Outpatient Serious Mental Illness. See: Definition of "Serious Mental Illness."	Eligible expenses covered at **100%** after **applicable** Copayment per visit.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

PPO 0076

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (continued)			
Inpatient chemical dependency treatment as required by State law.	Eligible Facility-Hospital expenses subject to **$500.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **80%** after Plan Deductible is met. Lifetime maximum of 3 separate series of treatments per Participant as specified in accordance with Art. 3.51-9 of the Texas Insurance Code. Lifetime maximum will be computed to include inpatient and outpatient treatment under this Plan or any other City-sponsored plan, policy or HMO, whether currently or formerly offered.	Eligible Facility-Hospital expenses subject to **$1,000.00** Hospital Inpatient Copayment; covered at **60%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **60%** after Plan Deductible is met. Lifetime maximum of 3 separate series of treatments per Participant as specified in accordance with Art. 3.51-9 of the Texas Insurance Code. Lifetime maximum will be computed to include inpatient and outpatient treatment under this Plan or any other City-sponsored plan, policy or HMO, whether currently or formerly offered.	Eligible Facility-Hospital expenses subject to **$250.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **80%** after Plan Deductible is met. Lifetime maximum of 3 separate series of treatments per Participant as specified in accordance with Art. 3.51-9 of the Texas Insurance Code. Lifetime maximum will be computed to include inpatient and outpatient treatment under this Plan or any other City-sponsored plan, policy or HMO, whether currently or formerly offered.
Inpatient Serious Mental Illness. See: Definition of "Serious Mental Illness."	Eligible Facility-Hospital expenses subject to **$500.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **80%** after Plan Deductible is met.	Eligible Facility-Hospital expenses subject to **$1,000.00** Hospital Inpatient Copayment; covered at **60%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **60%** after Plan Deductible is met.	Eligible Facility-Hospital expenses subject to **$250.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **80%** after Plan Deductible is met.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (continued)			
Inpatient Mental Illness (other than Serious Mental Illness)	Eligible Facility-Hospital expenses subject to **$500.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **80%** after Plan Deductible is met. Maximum of 30 days per Calendar Year. One-half (1/2) day inpatient benefit will be traded for one day in a participating psychiatric day care facility. In addition to the 30 days provided above, one-half (1/2) day inpatient benefit may be traded for 1 day in a non-residential day treatment facility.	Eligible Facility-Hospital expenses subject to **$1,000.00** Hospital inpatient Copayment; covered at **60%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **60%** after Plan Deductible is met. Maximum of 15 days per Calendar Year. One-half (1/2) day inpatient benefit will be traded for one day in a participating psychiatric day care facility. In addition to the 15 days provided above, one-half (1/2) day inpatient benefit may be traded for 1 day in a non-residential day treatment facility.	Eligible Facility-Hospital expenses subject to **$250.00** Hospital inpatient Copayment; covered at **80%** thereafter. Eligible expenses other than for the Facility-Hospital, such as for the attending Physician's services, covered at **80%** after Plan Deductible is met. Maximum of 30 days per Calendar Year. One-half (1/2) day inpatient benefit will be traded for one day in a participating psychiatric day care facility. In addition to the 30 days provided above, one-half (1/2) day inpatient benefit may be traded for 1 day in a non-residential day treatment facility.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
FAMILY PLANNING AND INFERTILITY SERVICES			
Family Planning	Eligible expenses covered at **100%** after **applicable Physician Office Visit** Copayment as follows: Physical exams, related laboratory tests, medical supervision, information and counseling regarding contraception, including prescribing contraception. An additional Copayment applies to the following services: • Insertion or removal of intra uterine device (IUD). **$30.00** additional Copayment. Cost of IUD is included. • Diaphragm and diaphragm fitting. **$30.00** additional Copayment. • Vasectomy. **$30.00** additional Copayment. • Tubal ligation. **$30.00** additional Copayment. Insertion or removal of a birth control device (such as Norplant) implanted under the skin. Eligible expenses covered at **50%** after Plan Deductible is met.	Eligible expenses covered at **60%** after Plan Deductible is met. For the following: Physical exams, related laboratory tests, medical supervision, information and counseling regarding contraception, including prescribing contraception. Services such as listed below are covered as stated above. • Insertion or removal of intra uterine device (IUD). • Diaphragm and diaphragm fitting. • Vasectomy. • Tubal ligation. Insertion or removal of a birth control device (such as Norplant) implanted under the skin. Eligible expenses covered at **50%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met. For the following: Physical exams, related laboratory tests, medical supervision, information and counseling regarding contraception, including prescribing contraception. Services such as listed below are covered as stated above. • Insertion or removal of intra uterine device (IUD). • Diaphragm and diaphragm fitting. • Vasectomy. • Tubal ligation. Insertion or removal of a birth control device (such as Norplant) implanted under the skin. Eligible expenses covered at **50%** after Plan Deductible is met.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
FAMILY PLANNING AND INFERTILITY SERVICES (continued)			
Infertility Services	Diagnostic testing to determine the cause of infertility and medical services to correct the cause of infertility are covered at the same benefit levels as medical services in general, but require Administrator's **pre-authorization**. See applicable outpatient and inpatient benefits descriptions for Copayments, Deductibles and Coinsurance.	**Not Covered**	Diagnostic testing to determine the cause of infertility and medical services to correct the cause of infertility are covered at the same benefit levels as medical services in general, but require Administrator's **pre-authorization**. See applicable outpatient and inpatient benefits descriptions for Copayments, Deductibles and Coinsurance.
	Artificial insemination is covered with a Copayment equal to **50%** after Plan Deductible is met for each procedure (but the cost of sperm is not covered.)	Artificial insemination is not covered.	Artificial insemination is not covered.
	The following services are not covered: Reversal of voluntary sterilization; gamete intrafallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); related to surrogate parenting, in vitro fertilization (IVF); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug therapies for stimulating ovulation (such as Pergonal or other menotropins); any costs of infertility services required because of a sex change by Participant or Participant's partner; or any other assisted reproductive technology or related treatment not specified as covered above.	The following services are not covered: Reversal of voluntary sterilization; gamete intrafallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); related to surrogate parenting, in vitro fertilization (IVF); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug therapies for stimulating ovulation (such as Pergonal or other menotropins); any costs of infertility services required because of a sex change by Participant or Participant's partner; or any other assisted reproductive technology or related treatment not specified as covered above.	The following services are not covered: Reversal of voluntary sterilization; gamete intrafallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); related to surrogate parenting, in vitro fertilization (IVF); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug therapies for stimulating ovulation (such as Pergonal or other menotropins); any costs of infertility services required because of a sex change by Participant or Participant's partner; or any other assisted reproductive technology or related treatment not specified as covered above.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
	INPATIENT SERVICES		
Inpatient Services - medical, surgical and obstetrical services	The Administrator's **pre-authorization** is required for all admissions to any Hospital, skilled nursing facility or other inpatient facility except for purpose of "Emergency Care." Admissions are approved for a specific period of time. The Participant will bear the cost for any portion of an inpatient confinement that exceeds the authorized stay. Eligible Hospital expenses are subject to **$500.00** Hospital Inpatient Copayment and are covered at **80%** thereafter. The following are examples of eligible Hospital expenses: Room charges, operating room and related facilities, anesthesia and oxygen service, intensive care and other special care units and services, X-ray, laboratory and other diagnostic tests, prescription medications and biologicals for use while in the Hospital, radiation and inhalation therapies, rehabilitation and physical therapies and whole blood, blood derivatives or blood components. Also covered is the processing and storage costs if Participant donates his or her own blood prior to the Participant's scheduled elective procedure.	The Administrator's **pre-authorization** is required for all admissions to any Hospital, skilled nursing facility or other inpatient facility except for purpose of "Emergency Care." Failure to receive **pre-authorization** will result in an additional **$250.00** Copayment per Hospital confinement that is in addition to the Hospital Inpatient Copayment. Admissions are approved for a specific period of time. The Participant will bear the cost for any portion of an inpatient confinement that exceeds the authorized stay. Eligible Hospital charges are subject to **$1,000.00** Hospital Inpatient Copayment and are covered at **60%** thereafter. The following are examples of eligible Hospital expenses: Room charges, operating room and related facilities, anesthesia and oxygen service, intensive care and other special care units and services, X-ray, laboratory and other diagnostic tests, prescription medications and biologicals for use while in the Hospital, radiation and inhalation therapies, rehabilitation and physical therapies and whole blood, blood derivatives or blood components. Also covered is the processing and storage costs if Participant donates his or her own blood prior to the Participant's scheduled elective procedure.	The Administrator's **pre-authorization** is required for all admissions to any Hospital, skilled nursing facility or other inpatient facility except for purpose of "Emergency Care." Failure to receive **pre-authorization** will result in an additional **$250.00** Copayment per Hospital confinement that is in addition to the Hospital Inpatient Copayment. Admissions are approved for a specific period of time. The Participant will bear the cost for any portion of an inpatient confinement that exceeds the authorized stay. Eligible Hospital charges are subject to **$250.00** Hospital Inpatient Copayment and are covered at **80%** thereafter. The following are examples of eligible Hospital expenses: Room charges, operating room and related facilities, anesthesia and oxygen service, intensive care and other special care units and services, X-ray, laboratory and other diagnostic tests, prescription medications and biologicals for use while in the Hospital, radiation and inhalation therapies, rehabilitation and physical therapies and whole blood, blood derivatives or blood components. Also covered is the processing and storage costs if Participant donates his or her own blood prior to the Participant's scheduled elective procedure.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Inpatient Services - medical, surgical and obstetrical services (continued)	Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter. The Plan covers inpatient care following childbirth for Participants and their newborn children for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section, if determined to be Medically Necessary by the Participants' Physician or requested by the Participant. In the event that the Participant or the Participant's newborn is discharged from inpatient care before the expiration of the minimum hours of coverage described above, the Plan will cover a post-delivery outpatient visit. The visit may take place at a Provider's office or in the Participant's home. Post delivery care services include maternal and neonatal physical assessments; parent education, assistance and training in breast-feeding and bottle-feeding; and the performance of any Medically Necessary and appropriate clinical tests. The services may be provided by a Physician, registered nurse or other licensed health care professional. This visit is in addition to your coverage for outpatient post natal obstetricalcare. A separate Hospital Inpatient Copayment is not required for a newborn child at the time of delivery. If a newborn child is discharged and	Services other than those provided by the Hospital, such as attending Physician services and surgeon services are subject to the Plan Deductible and covered at **60%** thereafter; radiologist, pathologist and anesthesiologist services (only if hospital or surgeon is In-network) are subject to Plan Deductible and covered at **80%** thereafter, otherwise covered at **60%**. The Plan covers inpatient care following childbirth for Participants and their newborn children for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section, if determined to be Medically Necessary by the Participant's Physician or requested by the Participant. In the event that the Participant or the Participant's newborn is discharged from inpatient care before the expiration of the minimum hours of coverage described above, the Plan will cover a post-delivery outpatient visit. The visit may take place at a Provider's office or in the Participant's home. Post delivery care services include maternal and neonatal physical assessments; parent education, assistance and training in breast-feeding and bottle-feeding; and the performance of any Medically Necessary and appropriate clinical tests. The services may be provided by a Physician, registered nurse or other licensed health care professional. This visit is in addition to your coverage for outpatient post-natal obstetrical care. A separate Hospital Inpatient Copayment	Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter. The Plan covers inpatient care following childbirth for Participants and their newborn children for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section, if determined to be Medically Necessary by the Participant's Physician or requested by the Participant. In the event that the Participant or the Participants' newborn is discharged from inpatient care before the expiration of the minimum hours of coverage described above, the Plan will cover a post-delivery outpatient visit. The visit may take place at a Provider's office or in the Participant's home. Post delivery care services include maternal and neonatal physical assessments; parent education, assistance and training in breast-feeding and bottle-feeding; and the performance of any Medically Necessary and appropriate clinical tests. The services may be provided by a Physician, registered nurse or other licensed health care professional. This visit is in addition to your coverage for outpatient post-natal obstetrical care. A separate Hospital Inpatient Copayment is not required for a newborn child at the time of delivery. If a newborn child is discharged and readmitted to a

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Inpatient Services - medical, surgical and obstetrical services (continued)	readmitted to a Hospital more than five (5) days after the date of birth, satisfaction of a separate Hospital Inpatient Copayment for such readmission will be required. The Plan covers inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection, unless the Participant or the Participant's attending Physician determine that a shorter period of inpatient care is appropriate. The Plan also covers reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry, including surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.	is not required for a newborn child at the time of delivery. If a newborn child is discharged and readmitted to a Hospital more than five (5) days after the date of birth, satisfaction of a separate Hospital Inpatient Copayment for such readmission will be required. The Plan covers inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection, unless the Participant or the Participant's attending Physician determine that a shorter period of inpatient care is appropriate. The Plan also covers reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry, including surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.	Hospital more than five (5) days after the date of birth, satisfaction of a separate Hospital Inpatient Copayment for such readmission will be required. The Plan covers inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection, unless the Participant or the Participant's attending Physician determine that a shorter period of inpatient care is appropriate. The Plan also covers reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry, including surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Semi-private room, meals, nursing care	Private room covered only if semi-private room is unavailable or if **pre-authorized** by the Administrator and necessary for isolation due to an infectious disease or immune problems. The Participant will pay the difference in the private and semi-private room charges if the Administrator does not **pre-authorized** the private room. Special diets are covered on the same basis as other Hospital expenses, but only when Medically Necessary and prescribed by the attending Physician. Special duty nursing is covered on the same basis as other Hospital expenses, but only if recommended by the attending Physician and **pre-authorized** by the Administrator.	Private room covered only if semi-private room is unavailable or if **pre-authorized** by the Administrator and necessary for isolation due to an infectious disease or immune problems. The Participant will pay the difference in the private and semi-private room charges if the Administrator does not **pre-authorized** the private room. Special diets are covered on the same basis as other Hospital expenses, but only when Medically Necessary and prescribed by the attending Physician. Special duty nursing is covered on the same basis as other Hospital expenses, but only if recommended by the attending Physician and **pre-authorized** by the Administrator.	Private room covered only if semi-private room is unavailable **pre-authorized** by the Administrator and necessary for isolation due to an infectious disease or immune problems. The Participant will pay the difference in the private and semi-private room charges if the Administrator does not **pre-authorized** the private room. Special diets are covered on the same basis as other Hospital expenses, but only when Medically Necessary and prescribed by the attending Physician. Special duty nursing is covered on the same basis as other Hospital expenses, but only if recommended by the attending Physician and **pre-authorized** by the Administrator.

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SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Rehabilitation, speech, occupational, and physical therapy; treatment for acquired brain injury	Covered on the same basis as other Hospital expenses when attending Physician authorizes services and the Administrator **pre-authorized** the services. Coverage is limited to services that continue to meet or exceed treatment goals established for the Participant. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Coverage for treatment of acquired brain injury will be the same as for treatment for any other physical condition. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an acquired brain injury.	Covered on the same basis as other Hospital expenses when attending Physician authorizes services and the Administrator **pre-authorized** the services. Coverage is limited to services that continue to meet or exceed treatment goals established for the Participant. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Coverage for treatment of acquired brain injury will be the same as for treatment for any other physical condition. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an acquired brain injury.	Covered on the same basis as other Hospital expenses when attending Physician authorizes services and the Administrator **pre-authorized** the services. Coverage is limited to services that continue to meet or exceed treatment goals established for the Participant. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Coverage for treatment of acquired brain injury will be the same as for treatment for any other physical condition. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered as a result of and related to an acquired brain injury.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Skilled nursing / Rehabilitation facility care	Eligible Facility expenses subject to **$500.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Copayment waived for transfer from inpatient Hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending Physician's services, are subject to the Plan Deductible and covered at **80%** thereafter. Coverage is limited to the following conditions: If Participant were not admitted to a skilled nursing facility, acute care hospitalization would be needed, the attending Physician authorizes the care and the Administrator **pre-authorized** the care. Coverage is also limited to a maximum of 60 days per Calendar Year. Custodial care or care for persistent illnesses and disorders that, in the Administrator's opinion, cannot be relieved or improved by medical treatment are not covered.	Eligible Facility expenses subject to **$1,000.00** Hospital Inpatient Copayment; covered at **60%** thereafter. Copayment waived for transfer from inpatient Hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending Physician's services, are subject to the Plan Deductible and covered at **60%** thereafter. Coverage is limited to the following conditions: If Participant were not admitted to a skilled nursing facility, acute care hospitalization would be needed, the attending Physician authorizes the care and the Administrator **pre-authorized** the care. Coverage is also limited to a maximum of 60 days per Calendar Year. Custodial Care or care for persistent illnesses and disorders that, in the Administrator's opinion, cannot be relieved or improved by medical treatment are not covered.	Eligible Facility expenses subject to **$250.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Copayment waived for transfer from inpatient Hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending Physician's services, are subject to the Plan Deductible and covered at **80%** thereafter. Coverage is limited to the following conditions: If Participant were not admitted to a skilled nursing facility, acute care hospitalization would be needed, the attending Physician authorizes the care and the Administrator **pre-authorized** the care. Coverage is also limited to a maximum of 60 days per Calendar Year. Custodial Care or care for persistent illnesses and disorders that, in the Administrator's opinion, cannot be relieved or improved by medical treatment are not covered.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Hospice Care	**Inpatient** - Eligible expenses subject to **$500.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Services other than those provided by hospice facility, such as attending Physician's services, are subject to the Plan Deductible and covered at **80%** thereafter. **Outpatient** – Eligible expenses covered at **100%** after **$30.00** Copayment.	**Inpatient** - Eligible expenses subject to **$1000.00** Hospital Inpatient Copayment; covered at **60%** thereafter. Services other than those provided by hospice facility, such as attending Physician's services, are subject to the Plan Deductible and covered at **60%** thereafter. **Outpatient** – Eligible expenses covered at **60%** Plan Deductible is met.	**Inpatient** - Eligible expenses subject to **$250.00** Hospital Inpatient Copayment; covered at **80%** thereafter. Services other than those provided by hospice facility, such as attending Physician's services, are subject to the Plan Deductible and covered at **80%** thereafter. **Outpatient** – Eligible expenses covered at **80%** after Plan Deductible is met.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
INPATIENT SERVICES (continued)			
Organ Transplants	Corneal transplants, liver transplants, kidney transplants, kidney transplants performed simultaneously with pancreas transplants, heart transplants, lung transplants, heart lung transplants, bone marrow transplants and peripheral stem cell transplants (the "Listed Transplants") are covered benefits. Eligible Hospital charges subject to **$500.00** Hospital Inpatient Copayment; covered at **80%** thereafter. There is no Hospital Inpatient Copayment applicable to the donor for the donor services covered hereunder. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter. Subject to the conditions described below, benefits for covered services and supplies provided to a participant by a Hospital; Physician, or Other Provider Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met: (1) The transplant procedure is not perimental/Investigational in nature; and Donated human	Corneal transplants, liver transplants, kidney transplants, kidney transplants performed simultaneously with pancreas transplants, heart transplants, lung transplants, heart lung transplants, bone marrow transplants and peripheral stem cell transplants (the "Listed Transplants") are covered benefits. Eligible Hospital charges subject to **$1,000.00** Hospital Inpatient Copayment; covered at **60%** thereafter. . There is no Hospital Inpatient Copayment applicable to the donor for the donor services covered hereunder. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **60%** thereafter. Subject to the conditions described below, benefits for covered services and supplies provided to a participant by a Hospital; Physician, or Other Provider Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met: (1) The transplant procedure is not perimental/Investigational in nature; and Donated human	Corneal transplants, liver transplants, kidney transplants, kidney transplants performed simultaneously with pancreas transplants, heart transplants, lung transplants, heart lung transplants, bone marrow transplants and peripheral stem cell transplants (the "Listed Transplants") are covered benefits. Eligible Hospital charges subject to **$250.00** Hospital Inpatient Copayment; covered at **80%** thereeafter. . There is no Hospital Inpatient Copayment applicable to the donor for the donor services covered hereunder. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter. Subject to the conditions described below, benefits for covered services and supplies provided to a participant by a Hospital; Physician, or Other Provider Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met: (1) The transplant procedure is not perimental/Investigational in nature; and Donated human

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	organs or tissue or an FDA-approved artificial device are used; and (2) The recipient is a Participant under the Plan; and (3), The transplant procedure is preauthorized as required under the Plan; and (4) The Participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and (5) The Participant meets all of the protocols established by the Hospital in which the transplant is performed. Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above. Benefits will be available for: (1) A recipient who is covered under this Plan; and (2) A donor who is a Participant under this Plan; or	organs or tissue or an FDA-approved artificial device are used; and (2) The recipient is a Participant under the Plan; and (6) The transplant procedure is preauthorized as required under the Plan; and (7) The Participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and (8) The Participant meets all of the protocols established by the Hospital in which the transplant is performed. Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above. Benefits will be available for: (4) under this Plan; and (5) A donor who is a Participant under this Plan; or (6) A donor who is not a Participant under this Plan.	organs or tissue or an FDA-approved artificial device are used; and (2) The recipient is a Participant under the Plan; and (9) The transplant procedure is preauthorized as required under the Plan; and (10) The Participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and (11) The Participant meets all of the protocols established by the Hospital in which the transplant is performed. Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above. Benefits will be available for: (7) (1) A recipient who is covered under this Plan; and (8) A donor who is a Participant under this Plan; or

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	(3) A donor who is not a Participant under this Plan. Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits" amount shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan. Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits for Transplants" shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan.	Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits" amount shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan. Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits for Transplants" shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan. (1) A recipient who is covered	(9) A donor who is not a Participant under this Plan. Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits" amount shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan. Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits for Transplants" shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
	INPATIENT SERVICES (continued)		
Organ Transplants (continued)	Covered services and supplies include services and supplies provided for the: (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and (2) Removal of organs or tissues from living or deceased donors; and (3) Transportation and short-term storage of donated organs or tissues. No benefits are available for a Participant for the following services or supplies: (1) Living and/or travel expenses of the recipient or a live donor; (2) Donor search and acceptability testing of potential live donors; (3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation; (4) Purchase of the organ or tissue; or (5) Organs or tissue (xenograft) obtained from another species. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about preauthorization.	Covered services and supplies include services and supplies provided for the: (4) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and (5) Removal of organs or tissues from living or deceased donors; and (6) Transportation and short-term storage of donated organs or tissues. No benefits are available for a Participant for the following services or supplies: (6) Living and/or travel expenses of the recipient or a live donor; (7) Donor search and acceptability testing of potential live donors; (8) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation; (9) Purchase of the organ or tissue; or (10) Organs or tissue (xenograft) obtained from another species. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about preauthorization.	Covered services and supplies include services and supplies provided for the: (7) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and (8) Removal of organs or tissues from living or deceased donors; and (9) Transportation and short-term storage of donated organs or tissues. No benefits are available for a Participant for the following services or supplies: (11) Living and/or travel expenses of the recipient or a live donor; (12) Donor search and acceptability testing of potential live donors; (13) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation; (14) Purchase of the organ or tissue; or (15) Organs or tissue (xenograft) obtained from another species. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about preauthorization.

	(1) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization. (2) At the time of preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claims Administrator considers to be Experimental/ Investigational.	(2) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization. (2) At the time of preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claims Administrator considers to be Experimental/ Investigational.	(3) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization. (2) At the time of preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claims Administrator considers to be Experimental/ Investigational.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES			
Limited dental-related services	Benefits for those limited services that are covered will be on the same basis as for other covered services. See applicable outpatient and inpatient benefits descriptions. Coverage is limited as provided below: Treatment of a fractured or dislocated jaw or damage to sound natural teeth if the fracture, dislocation or damage results from an accidental injury; treatment must occur while Participant's coverage under the Plan is in effect; Participant must seek treatment within 72 hours of the accidental injury and complete treatment within 24 months of the accident. The attending Physician must authorize the treatment, and the Administrator must **pre-authorize** the treatment. A sound natural tooth is defined as any tooth which is in good health and is free of any of the following: root canal, crown, restoration (filling) involving three (3) or more surfaces, existing decay or periodontal disease.	Benefits for those limited services that are covered will be on the same basis as for other covered services. See applicable outpatient and inpatient benefits descriptions. Coverage is limited as provided below: Treatment of a fractured or dislocated jaw or damage to sound natural teeth if the fracture, dislocation or damage results from an accidental injury; treatment must occur while Participant's coverage under the Plan is in effect; Participant must seek treatment within 72 hours of the accidental injury and complete treatment within 24 months of the accident. The attending Physician must authorize the treatment, and the Administrator must **pre-authorize** the treatment. A sound natural tooth is defined as any tooth which is in good health and is free of any of the following: root canal, crown, restoration (filling) involving three (3) or more surfaces, existing decay or periodontal disease.	Benefits for those limited services that are covered will be on the same basis as for other covered services. See applicable outpatient and inpatient benefits descriptions. Coverage is limited as provided below: Treatment of a fractured or dislocated jaw or damage to sound natural teeth if the fracture, dislocation or damage results from an accidental injury; treatment must occur while Participant's coverage under the Plan is in effect; Participant must seek treatment within 72 hours of the accidental injury and complete treatment within 24 months of the accident. The attending Physician must authorize the treatment, and the Administrator must **pre-authorize** the treatment. A sound natural tooth is defined as any tooth which is in good health and is free of any of the following: root canal, crown, restoration (filling) involving three (3) or more surfaces, existing decay or periodontal disease.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES (continued)			
Limited dental-related services (continued)	Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures) if the attending Physician authorizes the service and the Administrator **pre-authorizes**. Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw or craniomandibular) as a result of accident, a trauma, a congenital defect, a developmental defect or pathology, would be covered as any other illness, if the services are authorized by the attending Physician and **pre-authorized** by the Administrator.	Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures) if the attending Physician authorizes the service and the Administrator **pre-authorizes**. Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw or craniomandibular) as a result of accident, a trauma, a congenital defect, a developmental defect or pathology, would be covered as any other illness, if the services are authorized by the attending Physician and **pre-authorized** by the Administrator.	Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures) if the attending Physician authorizes the service and the Administrator **pre-authorizes**. Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw or craniomandibular) as a result of accident, a trauma, a congenital defect, a developmental defect or pathology, would be covered as any other illness, if the services are authorized by the attending Physician and **pre-authorized** by the Administrator.
Administration of Blood	The administration of blood, blood derivatives and blood components is covered. Also covered is the processing and storage costs if the Participant donates his or her own blood prior to the Participant's scheduled elective procedure. Eligible expenses covered at **80%** after Plan Deductible is met.	The administration of blood, blood derivatives and blood components is covered. Also covered is the processing and storage costs if the Participant donates his or her blood prior to the Participant's scheduled elective procedure. Eligible expenses covered at **60%** after Plan Deductible is met.	The administration of blood, blood derivatives and blood components is covered. Also covered is the processing and storage costs if the Participant donates his or her blood prior to the Participant's scheduled elective procedure. Eligible expenses covered at **80%** after Plan Deductible is met.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES (continued)			
Hospital Emergency Room	Eligible expenses covered at **80%** after **$150.00** Copayment. If Participant is determined to require Emergency Care and is admitted to the Hospital directly from the emergency room, then the foregoing is inapplicable and the Hospital admission will be covered at the same benefit levels as other inpatient services. If the Participant initially seeks Emergency Care from other than Participating providers, then the care must be transferred to Participating providers as soon as medically possible in order to continue to be eligible for In-Network benefits. See **Section 1** for this and other general requirements. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter.	Eligible expenses covered at **80%** after **$150.00** Copayment. If Participant is determined to require Emergency Care and is admitted to the Hospital directly from the emergency room, then the foregoing is inapplicable and the Hospital admission will be covered at the same benefit levels as other inpatient services. If the Participant initially seeks Emergency Care from other than Participating providers, then the care must be transferred to Participating providers as soon as medically possible in order to continue to be eligible for In-Network benefits. See **Section 1** for this and other general requirements. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter. **NOTE:** If you wait more than 48 hours to seek Emergency Care, the benefit is **60%** after **$150.00** Copayment and Plan Deductible are met.	Eligible expenses covered at **80%** after Plan Deductible has been met. If Participant is determined to require Emergency Care and is admitted to the Hospital directly from the emergency room, then the foregoing is inapplicable and the Hospital admission will be covered at the same benefit levels as other inpatient services. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter.

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SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES (continued)			
Urgent Care - in other than a Hospital emergency room	Benefits are available only through Participating Urgent Care providers and Participating Physicians. Eligible expenses covered at **100%** after a **$60.00** Copayment if the member uses a Participating Urgent Care facility. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter.	Eligible expenses covered at **60%** after Plan Deductible is met. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **60%** thereafter.	Eligible expenses covered at **80%** after Plan Deductible is met. Services other than those provided by the Hospital, such as attending Physician services, surgeon services, anesthesiologist services and radiologist services are subject to the Plan Deductible and covered at **80%** thereafter.
Ambulance Service	Eligible expenses covered at **80%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Allergy Testing/ Serum and Injections	Eligible expenses covered at **100%** after **applicable** Copayment when associated with a Physician's Office Visit. Eligible expenses covered at **80%** after Plan Deductible is met without an office visit.	Eligible expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

PPO 0097

Diabetic Equipment	Eligible expenses covered at **80%** after **$30** Copayment. Diabetic Equipment, Diabetic Self-Management Training and Diabetic Supplies are covered on the same basis as benefits are provided for treatment of other analogous chronic medical conditions. Also covered are: disposable or consumable outpatient Diabetic Supplies; Diabetic Equipment and Supplies that do not require a prescription under state law; and injectable insulin.	Eligible expenses covered at **60%** after Plan Deductible is met. Diabetic Equipment, Diabetic Self-Management Training and Diabetic Supplies are covered on the same basis as benefits are provided for treatment of other analogous chronic medical conditions. Also covered are: disposable or consumable outpatient Diabetic Supplies; Diabetic Equipment and Supplies that do not require a prescription under state law; and injectable insulin.	Eligible expenses covered at **80%** after Plan Deductible is met. Diabetic Equipment, Diabetic Self-Management Training and Diabetic Supplies are covered on the same basis as benefits are provided for treatment of other analogous chronic medical conditions. Also covered are: disposable or consumable outpatient Diabetic Supplies; Diabetic Equipment and Supplies that do not require a prescription under state law; and injectable insulin.
Prosthetic devices (an item that replaces all or part of any internal body organ or external body appendage) when due to an acute illness or injury that has occurred after the effective date of the Participant's enrollment in the Plan. Included are: an artificial arm, leg or eye, hearing aid, terminal device (hand or hook), permanent lens (following cataract surgery), external cardiac pacemaker, penile prosthesis, breast prosthesis (following breast surgery) or brace for arm, leg, back or neck **Note:** See **Section 3** for Limitations	Eligible expenses covered at **80%** after Plan Deductible is met.	Eligible Expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES (continued)			
Prosthetic devices (an item that replaces all or part of any internal body organ or external body appendage) when due to an acute illness or injury that has occurred after the effective date of the Participant's enrollment in the Plan. Included are: an artificial arm, leg or eye, hearing aid, terminal device (hand or hook), permanent lens (following cataract surgery), external cardiac pacemaker, penile prosthesis, breast prosthesis (following breast surgery) or brace for arm, leg, back or neck **Note:** See **Section 3** for Limitations	Eligible expenses covered at **80%** after Plan Deductible is met.	Eligible Expenses covered at **60%** after Plan Deductible is met.	Eligible expenses covered at **80%** after Plan Deductible is met.
Durable Medical Equipment	Eligible expenses covered at **80%** after Plan Deductible is met for the rental or purchase (initial placement only) of such equipment. Rental or purchase is determined by the Administrator. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Also covered hearing aid benefit of $1,000 per 36 month period.	Eligible expenses covered at **60%** after Plan Deductible is met for the rental or purchase (initial placement only) of such equipment. Rental or purchase is determined by the Administrator. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Also covered hearing aid benefit of $1,000 per 36 month period.	Eligible expenses covered at **80%** after Plan Deductible is met for the rental or purchase (initial placement only) of such equipment. Rental or purchase is determined by the Administrator. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Also covered hearing aid benefit of $1,000 per 36 month period.

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SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES (continued)			
Cosmetic, Reconstructive or Plastic Surgery	Eligible Expenses for Cosmetic, Reconstructive, or Plastic surgery will be the same as for treatment of any other illness as shown in your schedule of coverage for the following services only. *Treatment provided for the correction of defects incurred in an accidental injury sustained by the Participant, but only if treatment is sought within 24 hours of the accidental injury: *or treatment provided for reconstruction surgery following cancer surgery; *or surgery performed on a newborn child for the treatment or correction of a congenital defect; or surgery performed on a Dependent Child (other than a newborn child) under the age of 19 * for the treatment or correction of a congenital defect other than conditions of the breast; *or reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymph edemas, at all stages of the mastectomy; or reconstructive surgery performed on a Dependent Child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.	Eligible Expenses for Cosmetic, Reconstructive, or Plastic surgery will be the same as for treatment of any other illness as shown in your schedule of coverage for the following services only. *Treatment provided for the correction of defects incurred in an accidental injury sustained by the Participant, but only if treatment is sought within 24 hours of the accidental injury: *or treatment provided for reconstruction surgery following cancer surgery; *or surgery performed on a newborn child for the treatment or correction of a congenital defect; or surgery performed on a Dependent Child (other than a newborn child) under the age of 19 * for the treatment or correction of a congenital defect other than conditions of the breast; *or reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymph edemas, at all stages of the mastectomy; or reconstructive surgery performed on a Dependent Child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.	Eligible Expenses for Cosmetic, Reconstructive, or Plastic surgery will be the same as for treatment of any other illness as shown in your schedule of coverage for the following services only. *Treatment provided for the correction of defects incurred in an accidental injury sustained by the Participant, but only if treatment is sought within 24 hours of the accidental injury: *or treatment provided for reconstruction surgery following cancer surgery; *or surgery performed on a newborn child for the treatment or correction of a congenital defect; or surgery performed on a Dependent Child (other than a newborn child) under the age of 19 * for the treatment or correction of a congenital defect other than conditions of the breast; *or reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymph edemas, at all stages of the mastectomy; or reconstructive surgery performed on a Dependent Child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

SECTION 2 – What is Covered

SERVICE/PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK	OUT-OF-AREA
OTHER SERVICES (continued)			
Alzheimer's Disease	Eligible Expenses for treatment of patients with Alzheimer's Disease will be the same as for treatment of any other illness as shown on the Schedule of Benefits and limited to Physicians' charges, neuro-diagnostic testing, medication management and psychological therapy. (Specific speech, occupational and rehabilitation therapies, as approved by the Administrator.) Eligible expenses covered at **80%** after the Plan Deductible is met.	Eligible Expenses for treatment of patients with Alzheimer's Disease will be the same as for treatment of any other illness as shown on the Schedule of Benefits and limited to Physicians' charges, neuro-diagnostic testing, medication management and psychological therapy. (Specific speech, occupational and rehabilitation therapies, as approved by the Administrator.) Eligible expenses covered at **60%** after the Plan Deductible is met.	Eligible Expenses for treatment of patients with Alzheimer's Disease will be the same as for treatment of any other illness as shown on the Schedule of Benefits and limited to Physicians' charges, neuro-diagnostic testing, medication management and psychological therapy. (Specific speech, occupational and rehabilitation therapies, as approved by the Administrator.) Eligible expenses covered at **80%** after the Plan Deductible is met.
Other Services that are not specifically addressed in this Section 2 as being not covered or are not specifically excluded under Section 1 or 3 of this Schedule.	It is not possible in this document to list every possible covered medical service or procedure. Other Medically Necessary services, if **pre-authorized** by the Administrator (and, with respect to In-Network Services, recommended by your Physician), may be covered subject to the Copayments and Coinsurance applicable to the nature of the service and the type of coverage involved. If you have a question about whether a particular service not mentioned by name in this **Section 2** is covered, please call the Administrator or your Health Benefits Office.		
LIFETIME MAXIMUM BENEFIT			
***Lifetime Maximum Benefit (Does not apply to coverage or services for AIDS or human immunodeficiency virus infection. For these conditions only there is no lifetime maximum benefit limit.)**	**$1,500,000** per Participant		

***In-Network, Out-of-Network and Out-of-Area expenses are each added to compute the Lifetime Maximum Benefit. The Lifetime Maximum Benefit includes expenses incurred by the Participant under this Plan and any other current or former health plan sponsored by the Plan Sponsor, including HMOs, self-funded plans and insured plans.**

PPO 0101

SECTION 3 – EXCLUSIONS
(What Is Not Covered)

There are three general rules to remember regarding services that are not covered:

- Coverage for health-care services is specified in **Section 2** of this Plan Ddocument. If a service is not addressed as being covered in **Section 2**, it is not covered.
- Specific exclusions are specified below in this **Section 3**. If a service is excluded below, then it is not covered.

The Participant must always meet the conditions for coverage described in the other provisions of this Plan Document.

Unless specifically included in the Plan, the following services are not covered:

1. Cosmetic or other reconstructive procedures (including any related prostheses) that are not Medically Necessary. Among the procedures that are not covered are removal or altering of sagging skin; changing the appearance of any part of your body (such as enlargement, reduction or implantation); hair transplants or removal; peeling or abrasion of the skin; any procedure that does not repair a functional disorder; and any procedure that is primarily intended to improve physical appearance, whether for emotional, psychological or any other reasons. This exclusion does not apply to breast reconstruction following a mastectomy, including the breast on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed, and to one bra purchased after mastectomy surgery. This exclusion does not apply for one wig purchased in conjunction with chemotherapy. This exclusion also does not apply to reconstructive surgery performed on a Participant who is less than 19 years of age to improve the function of or to attempt to create a normal appearance of Craniofacial Abnormality.

2. Except as set forth above, breast reduction or augmentation (enlargement) surgery, even when Medically Necessary is not covered.

3. Dental treatments, diagnostics, services, appliances and supplies. For example, routine dental work, X-rays or exams; dentures; dental prostheses or cosmetic surgery for shortening or lengthening the jaw; orthodontics; splints; positioners or extracting teeth. The only dental-related coverage provided under the Plan is described in **Section 2** of this Plan Document, under **Other Services**.

4. Inpatient or outpatient Custodial Care. Custodial Care is care that primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes) or can be given by people other than trained medical personnel. Care can be custodial even if it is prescribed by a Physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters.

5. Inpatient or outpatient Custodial Care for persons with Alzheimer's disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, other persistent illness or disorder that, in the Administrator's opinion, cannot be significantly relieved or improved by medical treatment.

6. Reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug therapies for stimulating ovulation (such as Pergonal or other menotropins); any costs related to surrogate parenting; infertility services required because of a sex change by the Participant or the Participant's partner; or any assisted reproductive technology or related treatment that is not specified in **Section 2** of this Plan Document, under **Family Planning and Infertility Services.**

7. Transplants of organs, tissues, bone marrow and peripheral stem cells, except as specified in **Section 2** of this Plan Document, under **Inpatient Services.**

8. Experimental/Investigational procedures, services and supplies.

9. Health care services for any work-related injury or illness, unless no other source of coverage or reimbursement is (or was) available for the services. Sources of coverage or reimbursement available may include the employer, a work-related benefit plan maintained by the employer, and any workers' compensation, occupational disease or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available even if the Participant waived his right to payment from that source.

10. With the exception of Diabetic Diabetes Supplies, disposable or consumable outpatient supplies, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, ostomy bags, home testing kits,

oxygen, vitamins (except those vitamins which by law require a prescription order and for which there is no non-prescriptive alternative), dietary supplements and replacements, and special food items.

11. Elective, non-therapeutic termination of pregnancy.

12. All prosthetic items and devices, except for those specified in **Section 2** of this Plan Document. Excluded devices include, but are not limited to, orthopedic shoes (unless built into a leg brace), other supportive devices for the feet, devices provided solely for cosmetic purposes that have no functional application, dentures and eyeglasses. Devices are not included if considered experimental or research oriented by the Administrator's Medical Director, nor is deluxe equipment covered if a less expensive item would be functional. The Plan reserves the right to request a second opinion regarding the type, quality and/or feasibility of the device. The Plan does not cover the replacement, repair or maintenance of any prosthetic item or device that is not covered under **Section 2** of this Plan Document. The Plan does not cover the replacement, repair or maintenance of any device that is provided under **Section 2** of this Plan Document, except as required by growth of the Participant Member.

13. Educational testing and therapy, including the treatment of learning disabilities, developmental delays in speech, motor or language skills, behavioral disorders or services that are educational in nature or are for vocational testing or training, except for Therapies for Children with Developmental Delays as specified in **Section 2**. This exclusion does not apply to developmental delays if the delay is related to a treatable medical condition, in which case such treatment is limited as specified in **Section 2**.

14. Treatments and evaluations required by employers, insurers, schools, camps, courts, licensing authorities and other third parties. Special medical reports not directly related to treatment. Appearance at court hearings and other legal proceedings.

15. Any services or items for which the Participant has no legal obligation to pay, or for which no charge would ordinarily be made. Examples of this include care for conditions related to military service, care while in the custody of any government authority, and any care that is required by law to be given in a public facility.

16. Eyeglasses, contact lenses, and any other items or services for the correction of eyesight, including orthoptics, vision training, vision therapy and radial keratotomy or keratoplasty.

17. Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as specified in **Section 2.**

18 Any services, supplies or prescriptions provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.

19. Sex-change surgery and related treatment, including hormone therapy and medical or psychological counseling.

20. Any services or supplies provided for the following treatment modalities:

- video fluoroscopy;
- intersegmental traction;
- surface EMGs;
- manipulation under anesthesia; and
- muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron;
- Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy and aroma therapy;
- Galvanic stimulators; and
- Biofeedback or other behavior modification services.

21. Any services or supplies for routine foot care, such as:

- The cutting or removal of corns or callouses, the trimming of nails (including mycotic nails) and other hygienic and preventive care maintenance in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory or bedfast patients;
- Any services performed in the absence of localized illness, injury, or symptoms involving the foot;
- Any treatment of a fungal (mycotic) infection of the toenail in the absence of:
    - Clinical evidence of mycosis of the toenail;

The Plan Sponsor shall only exercise its rights above when, in its sole discretion, the Plan Sponsor determines that there is reasonable evidence or information to determine that the events set forth in (a), (b) or (c) above contributed to or caused the injury.

The Administrator shall identify all claims resulting from the events set forth above and shall notify the Plan Sponsor of such claims. The Administrator shall make a recommendation to the Plan Sponsor as to whether such claims shall continue to be paid. The Administrator shall provide records and data and shall provide other records as may be reasonably necessary for the Plan Sponsor to investigate and make a determination as to cause of injury. However, in all instances, the Plan Sponsor shall make the final determination to terminate a Participant's coverage related to an injury or to seek reimbursement for claims paid for the injury.

32. Drugs that may be obtained without a prescription under state law where the drug is dispensed, drugs and medication other than prescription drugs, therapeutic devices or appliances, including hypodermic needles and syringes, support garments, Durable Medical Equipment, drug infusion/metering devices, or prescription drugs intended for use in a practitioner's office or clinical setting; provided that the foregoing exclusion shall not apply to Diabetes Supplies or Diabetes Equipment; and

    Investigational or Experimental drugs, including Investigational New Drugs (IND) and drugs or compounded medications prescribed for a non-FDA approved indication, prescription drugs, that a Participant member is entitled to receive without charge from any workers' compensation laws or similar municipal, state or federal programs, and (for In-Network Services) prescription drugs not dispensed by Participating Pharmacies or Express Scripts, Inc. (except in cases of l Medical Emergency occurring outside the service Service Area); and

    Prescription drugs prescribed for cosmetic purposes, including tretinoin and Retin A (except when prescribed for acne vulgaris), and topical minoxidil, growth hormones, prescription drugs for smoking cessation unless otherwise stated in **Section 2** as and prescription drugs prescribed as anorexients (appetite suppressants) or for weight reduction; and

    Injectable prescription drugs (except insulin), blood or urine testing devices (except as used in the treatment of diabetes or if self-administered subcutaneously), and except as provided in **Section 2** of this Plan Document, contraceptive devices, (except oral contraceptives and diaphragms), including intra-uterine devices (IUD), cervical caps and Norplant; and

    Oxygen gas for outpatient use, prescription drugs written prior to the effective date of coverage, topical fluoride preparations, and prescription drugs prescribed primarily for the promotion of fertility.

33. Expenses for motorized beds, motorized wheel chairs, comfort items, bedboards, bathtub lifts, over bed tables, air purifiers, disposable supplies, elastic stockings, sauna baths, repair, replacement or maintenance of Durable Medical Equipment, exercise equipment, stethoscopes and sphygmomanometers, orthopedic shoes, arch supports, dentures, experimental or research items. Rental or purchase, as authorized by the Administrator, of durable medical equipment that is covered under the Plan will be limited to the conventional non-deluxe grade or model, and the medical needs and capability of the Participant and his care providers will be considered

34. Charges for detecting and correcting body distortion, except as set forth below. "Body distortion" means structural imbalance, distortion, or incomplete or partial dislocation in the human body:

    a. which interferes with the human nerves; and

    b. which is due to or related to distortion, misalignment or incomplete or partial dislocation of or in the vertebral column,

    that exceed an annual limit of $1,000 for any Participant. The foregoing limit also includes all associated services, such as X-rays, laboratory procedures and medications.

35. Any medical procedure performed on an inpatient basis, if, in the opinion of the Administrator, it could have been performed on an outpatient basis without jeopardizing the Participant's health.

36. Any services or supplies provided primarily for:

    a. Environmental Sensitivity; or

b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or

c. Inpatient allergy testing or treatment.

37. Any medical social services; any outpatient family counseling and/or therapy, bereavement counseling (except as provided as Hospice Care), vocational counseling, pastoral counseling, or Marriage and Family Therapy and/or counseling.

38. Any services or supplies provided for orthognathic surgery after the Participant's 19th birthday, except as may be specified in **Section 2**. Orthognathic surgery includes, but is not limited to, correction of congenital, developmental or acquired maxillofacial skeletal deformities of the mandible and maxilla.

39. Any services or supplies provided for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.

40. Any services relating to judicial or administrative proceedings or conducted as part of medical research.

41. Any services or supplies provided for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with: oral appliances; oral splints; oral orthotics; devices; prosthetics; dental restorations; orthodontics; physical therapy; or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent correlated muscles and nerves. Medically Necessary diagnostic and/or surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology is covered.

42. Residential treatment centers for chemical dependency other than facilities:

a. affiliated with a hospital under a contractual agreement with an established system for patient referral;

b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;

c. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

d. licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

43. Trauma or wilderness programs for behavioral health or chemical dependency treatment.

44. Services provided to Participants by individual related by blood or marriage.

45. Any portion of a charge for a service or supply that is in excess of the Usual and Customary Charge.

46. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality; provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

47. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.

48. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

49. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

50. Any benefits in excess of any specified maximums.

51. Any services or supplies not specifically defined as eligible expenses in this Plan.

52. Any special services provided by the pharmacy, including but not limited to, counseling and delivery.

53. Any prescription antiseptic or fluoride mouth rinses, or topical oral solutions or preparations.

54. Drugs dispensed in quantities in excess of the Day day Supply supply amounts stipulated in **Section 2,** certain Covered covered Drugs drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or by law except as pre-authorized by a Physician, or any drugs or medicines dispensed more than one year following the prescription order date.

55. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

56. Drugs used or the intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

57. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Participant's Identification Card.

58. Rogaine, minoxidil, or any other drugs, medications solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

59. Prescription orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength.

60. Athletic performance enhancement drugs.

61. All Prescription and Over-the-Counter Non–Sedating Antihistamine drugs, including, but not limited to, cetirizine (Zyrtec), desloratadine (Clarinex), fexofenadine (Allegra), loratadine (Claritin), loratadine & pseudoephedrine (Claritin-D) and fexofenadine & pseudoephedrine (Allegra-D). This includesdrugs with the same or similar chemical compound or make-up with the identical mode of action or outcome.

62. Drugs and devices to treat sexual dysfunction, including, but not limited to,sildenafil citrate (Viagra, Cialis, Levitra) and alprostadil (Prostin, Edex,Caverject), in oral or topical form. This includes drugs and devices with the same or similar chemical compound or make-up with the identical mode of action or outcome.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, coinsurance and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

EXHIBIT A-1

RETIREES' HOSPITALIZATION AND MEDICAL-SURGICAL PROGRAM

TABLE OF CONTENTS

COVERED ORAL SURGERY means maxillofacial surgical procedures limited to: (2) excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts; (2) incision and drainage of cellulitis; (3) surgical procedures involving accessory sinuses, salivary glands and ducts; and (4) reduction of dislocation of, excision of, and injection of the temporomandibular joint (does not include any type of correction of the occlusion of the teeth to eliminate temporomandibular joint pain or dysfunction).

DEPENDENT means:

1. A Retiree's spouse, or

2. Any unmarried Child who is:

   a. Under nineteen (19) years of age; or

   b. Nineteen (19) years of age or older, but less than twenty-five (25) years of age, who is attending an accredited educational institution as a full-time student; or

   c. Disabled, provided that in the case of a Child nineteen (19) years of age or older, such Child is dependent upon the Retiree for more than one-half of his support as defined by the Internal Revenue Code of the United States. As a condition to the continued coverage of a Child as a Disabled Dependent, the Planholder shall have the right to require periodic certification of the Child's physical or mental condition but not more frequently than annually after the two-year period following the Child's loss of eligibility under the other provisions of this definition.

The term DEPENDENT shall not be held to include (1) a legally separated spouse, (2) a spouse or Child on active military duty for any country, or (3) a Child who does not reside with the Retiree, unless the Retiree is required to provide medical support for the Child under a court decree.

DISABLED means any medically determinable physical or mental condition that prevents a person from engaging in self-sustaining employment, provided that satisfactory proof of such disability and dependency is submitted by the Retiree.

HOSPITAL means a Hospital that is licensed as such under the laws of Texas or the applicable laws of the jurisdiction in which it is situated, for the rendition of Care to patients on an admitted basis.

HOSPITAL ADMISSION means the period between the time of a Participant's entry into a Hospital as a bed-patient and the time of discontinuance of Hospital Care or discharge by the Physician, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission.

INTENSIVE CARE UNIT means a facility of a Hospital, apart from patients' bedrooms, operating rooms, or recovery rooms, that is used for patients whose conditions require unusual nursing Care, beyond the general nursing services provided by a Hospital. The term does not include the services of private special-duty nurses.

MEDICAL EMERGENCY means the sudden and unexpected onset of a condition requiring medical or surgical Care that the Participant secures immediately after the onset (or as soon thereafter as the Care can be made available but, in any case, no later than six (6) hours after the onset). Medical emergencies include, but are not limited to, heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, and convulsions.

OUTPATIENT CARE means Hospital Care rendered to a Participant at any time other than during a Hospital Admission.

PARTICIPANT means a Retiree or a Dependent who holds coverage hereunder.

PERIOD OF HOSPITAL CONFINEMENT means the combination of any number of Hospital Admissions of a Participant due to the same or related causes. When (1) a later admission commences after the Participant is no longer Totally Disabled from the sickness or injury causing an earlier admission, or (2) a later admission results from causes entirely unrelated to the cause of an earlier admission, a new Period Of Hospital Confinement begins.

PHYSICIAN means a person (other than a Hospital resident or intern) who is a Doctor of Medicine, Doctor of osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, or Doctor of Chiropractic, or a psychologist who is certified and licensed by law. The terms Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, and Doctor of Chiropractic as used herein, shall have the meanings assigned to them by law.

PLAN means the Retirees' Hospital and Medical-Surgical Program of benefits described in this document.

PLAN MONTH means a calendar month.

PLANHOLDER means the City of Houston.

PREADMISSION TESTING means tests performed in a Hospital on an outpatient basis that are:

1. Performed after admission to the Hospital has been determined to be medically necessary;

2. Performed after the admission has been scheduled;

3. Performed in lieu of tests following admission; and

4. Required by the rules and regulations of the Hospital's medical staff before Hospital bed-patient treatment of the condition diagnosed can commence; provided that the patient is subsequently admitted to the Hospital and the scheduled admission commences within ten (10) days from the time the tests were made.

PRIOR PLAN means the Retirees' Hospitalization and Medical-Surgical Program established by City of Houston Ordinance No. 83-1217, as amended.

RELATED TO THE PATIENT BY BLOOD OR MARRIAGE means a Retiree, the spouse of a Retiree, or a Child, brother, sister or parent of the Retiree or of the spouse of the Retiree.

RETIREE means a retired employee who is receiving retirement benefits under any one of the several retirement Plans that pertain to employees of the Planholder.

SCHEDULE means the attached Schedule of Specifications.

TOTALLY DISABLED means that the Participant is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

ARTICLE II. ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY FOR COVERAGE

This Plan is intended solely for the purpose of continuing benefits to Participants in the Prior Plan. This Plan is generally closed to enrollment. Participation is limited to:

1. Participants who hold coverage under the Prior Plan and who elect to continue that coverage by converting to this Plan during the enrollment period preceding the commencement of this Plan; and

2. Family members acquired by Retirees as new Dependents after the commencement of this Plan.

Coverage of the Retiree shall be a condition precedent to coverage of his eligible Dependents.

B. APPLICATION FOR COVERAGE

Coverage of each eligible Retiree or Dependent shall be contingent upon the Retiree's making application therefore in accordance with the approved procedures established by the Planholder; thereupon, subject to acceptance by the Planholder, coverage shall become effective in accordance with the following sections of this Article II.

C. EFFECTIVE DATES--PRIOR PLAN MEMBERS

Coverage of Prior Plan members who duly elect to convert to coverage hereunder shall become effective upon the commencement of this Plan, and shall relate back to their period of participation in the Prior Plan.

D. EFFECTIVE DATE--NEW DEPENDENTS

Coverage of a newly acquired Dependent of a Retiree is contingent upon application being made within thirty-one (31) days following his becoming eligible as a Dependent hereunder, and the payment of contributions retroactively to the eligibility date. If the application is made more than thirty-one (31) days after the eligibility date, no coverage will be available. Coverage is retroactive to the eligibility date, provided that in any instance in which a Dependent is confined for medical Care or treatment either in a Hospital or at home on the date his coverage would otherwise become effective, the coverage shall not become effective until the day following release from all medical Care or treatment by a Physician.

E. RESTORATION

A Participant who terminates coverage in this Plan is not eligible to rejoin.

ARTICLE III. CONTRIBUTIONS

Participant contributions required for coverage hereunder shall be as established from time to time by the Planholder's City Council. Notwithstanding any other provision that may be construed to the contrary, all benefits under this Plan are expressly subject to available funding, and the Planholder shall have no obligation to make funds available.

ARTICLE IV. PAYMENT OF BENEFITS; NON-DUPLICATION

A. BENEFITS

Subject to the qualifications, limitations, and exclusions set forth herein, Planholder will provide the benefits listed for Care furnished by Hospitals as detailed in Article V. Payment of benefits by Planholder to the Hospital supplying the Care or to the Retiree shall constitute full discharge of all responsibility of Planholder to the Retiree on account of Care rendered to any Participant under this Plan.

B. OBLIGATION OF PLANHOLDER

Subject to the qualifications, limitations and exclusions set forth herein, when obligated for the provision of benefits hereunder, Planholder will pay the Physician's charges for services rendered, in accordance with Article VI, provided, however, that:

Such payment shall not exceed the amount specified in Article VI; and

Such services must be performed by a Physician as defined herein.

It is understood and agreed that the allowances set out in Article VI are not intended to and do not fix the value of the services of the attending Physician nor in any way relate to or regulate such value; that the attending Physician is privileged to make his regular charges and that the stipulated amounts are merely to apply as credits thereon. All payments for operations or services as set forth in Article VI are payable to the Physician rendering the service, except that such payments will be made to the Retiree if he so directs before payment is made to the Physician. Such payment in either event shall constitute full discharge of all responsibility of Planholder to the Retiree for benefits on account of such services.

C. BENEFITS PAYABLE TO DECEASED RETIREE

Any benefits hereunder payable to the Retiree, if unpaid at his death, shall be paid to the surviving spouse of the Retiree, as beneficiary; if there is no surviving spouse, then such benefits shall be paid to the Retiree's estate.

D. ASSIGNMENT

The benefits provided hereunder may be assigned, in writing, to the provider of the covered services.

E. COORDINATION OF BENEFITS

This Plan is subject to coordination of benefits. The benefits specified herein are contingent upon the absence of other coverage. To the extent that other coverage is available, then the benefits shall be coordinated in accordance with the provisions of Article XI of the City of Houston Point of Service Health Program, which are incorporated by reference, except that Section B thereof shall not be fully applicable so that combined 100% coverage shall be allowed hereunder. A written procedure for coordination of benefits may be promulgated from time to time by the Planholder's Personnel Director, subject to the approval the person or firm retained by the Planholder to act as the administrator of the Plan.

F. PRIOR PLAN

The creation of this Plan was intended as a nonsubstantive revision of the Prior Plan. While certain provisions relating to administration of benefits and other matters have been revised, this Plan is intended to provide the exact same benefits available under the Prior Plan. To the extent of any substantive inconsistency, the provisions of the Prior Plan shall be controlling of benefits hereunder.

ARTICLE V. HOSPITALIZATION BENEFITS

A. NUMBER OF DAYS AVAILABLE

The number of days specified in item 2 of the Schedule shall determine the maximum periods of time during which the benefits detailed in this Article shall be available for bed patient Care of a Participant during each Period Of Hospital Confinement.

A-I. PRECERTIFICATION; CONCURRENT REVIEW

The purpose of this provision is to provide the contract administrator retained by the Planholder for the Plan a viable means of predetermining that inpatient Hospital services provided to Participants are medically indicated, that medical services are delivered in a timely manner to Participants during their hospitalizations, that Participants are released from inpatient Hospital Care when that Care is no longer medically indicated, that tests performed and other services rendered to Participants during their hospitalizations are medically indicated, that charges to the Participants reflect services actually received and that the charges are usual and customary. For these purposes the contract administrator

will precertify inpatient Hospital Admissions and follow the Participant's Care while admitted through professional medical personnel retained by the contract administrator. Nothing in this provision shall be construed to limit any Participant's free choice of Physician, Hospital, medical services, or treatment. However, precertification of bed patient Hospital Admissions by the contract administrator will be strictly enforced, and in accordance with the terms of Section B, of this Article, the per-hospital-admission deductible will only be waived for admissions that are timely precertified. Additionally, the Planholder reserves the right to delay the payment of any claim upon which precertification is not timely obtained or upon which the review process conducted during the hospitalization by the contract administrator has detected potential service or billing irregularities until a comprehensive and detailed audit of the services performed and charges imposed has been completed and all disputes arising therefrom have been resolved.

B. PER-HOSPITAL-ADMISSION DEDUCTIBLE

There shall be a per-hospital-admission deductible in the amount specified in item 4 of the Schedule, per Participant, for each Hospital Admission, which shall be deducted from the otherwise eligible expenses that are compensable under the Plan prior to the determination of any benefit amounts compensable under the Plan for each Hospital Admission by each Participant. The per-hospital-admission deductible shall be waived in its entirety if the following conditions are complied with:

1. For admissions other than due to a Medical Emergency, the admission is precertified by the contract administrator before the admission of the Participant to the Hospital as a bed patient in accordance with Section A-1, of this Article; or

2. For admissions due to a Medical Emergency, the admission is precertified by the contract administrator in accordance with Section A-1 of this Article, within 48 hours of the time that the Participant is admitted to the Hospital as a bed patient or before the time of the Participant's discharge from the Hospital as a bed patient, whichever time occurs first.

C. INTENSIVE CARE

The amounts specified in item 3 of the Schedule shall be the maximum benefit allowance for Care provided to a Participant in an Intensive Care Unit during each Period of Hospital Confinement.

This benefit shall be provided in lieu of any other allowance for room, board, and general nursing Care during the same period.

D. BENEFITS FOR MEDICAL CARE OR SURGICAL CARE IN A HOSPITAL

Subject to the limitations, exclusions and other provisions set forth herein, when any Participant receives services described below, he shall be entitled to benefits as described in this Section; provided however, the maximum total benefits available for any one Period Of

Hospital Confinement under Subsections 1b, 2 and 3 of this Section D shall not exceed 100% of the first $400.00 of eligible charges plus 75% of the next $10,000 of such charges.

1. Bed-Patient Care
   a. A daily allowance to apply on the charge for room accommodations, including meals, special diets, and general nursing services, not exceeding that specified in item 1 of the Schedule for the period of confinement not exceeding the number of days set forth in Section A of this Article. The daily allowance for room and board will not be payable on days when a Participant incurs expense for an intensive or coronary Care unit eligible for payment under Subsection 1b, below.

   b. All other Care in the nature of usual Hospital services furnished directly to the Participant and used by him while in the Hospital, including but not limited to the following services:

      (1) Blood and plasma, transfusion services, blood typing, and crossmatching of the blood of the patient and donors;

      (2) An anesthetic and its administration, when rendered in the Hospital and charged for by a Physician;

      (3) Intensive Care and Coronary Care units.

2. Outpatient Care

   All Care in the nature of outpatient Hospital services furnished by a Hospital (a) as the result of Accidental Injury occurring not more than forty-eight (48) hours preceding the outpatient visit, or (b) for minor surgery performed during the course of the outpatient visit, or (c) for Preadmission Testing.

3. Professional ambulance services for local travel in transporting the patient to and from the Hospital.

E. DELETED

F. BENEFITS FOR MATERNITY CARE IN A HOSPITAL

Benefits for maternity care shall be available in the same manner as for the other covered services.

G. BENEFITS FOR ACCIDENTAL INJURY EXPENSE

When any Participant, while covered hereunder and during a calendar year, shall sustain accidental bodily injury, Planholder will pay the Accidental Injury Expense incurred within the ninety (90) day period following the occurrence of the Accidental Injury, and as a result thereof; provided, however, that the total amount of benefits to be provided under this

Section G for any Participant arising out of any one Accidental Injury shall be limited to $300.00.

If there are any eligible expenses remaining after payment under this Section G, such expenses shall be payable in accordance with the provisions of the other sections of this Article V and Article VI.

H. DELETED

I. EFFECT OF TERMINATION OF COVERAGE

If termination of coverage of a Participant occurs for any reason and if the Participant is under the Care of a Physician and Totally Disabled from a sickness or injury on the date of termination of his coverage, benefits for expenses for that Participant incurred under Article V, Section D of this Plan during a Hospital confinement commencing within ninety (90) days from the date of termination of coverage and related solely to that sickness or injury will be available for the remainder of that Hospital confinement or until Plan benefits are exhausted, whichever occurs first. This provision shall be regarded as a continuation of the corresponding clause in the Prior Plan, and any benefits for services rendered under this provision after the commencement of this Plan shall be regarded as benefits incurred under this Plan.

ARTICLE VI. MEDICAL-SURGICAL BENEFITS

A. SURGICAL BENEFITS

The Surgical Benefits described below are available under this Plan up to the maximum allowance listed for each procedure.

When two or more operations or procedures are performed through the same incision, only the procedure commanding the highest allowance will be paid, not to exceed a maximum of $300.00.

When two or more unrelated operations or procedures are performed at the same time through different surgical openings or by different surgical approaches, the amount payable will be the allowance for each operation or procedure performed as specified below.

When two or more related operations or procedures are performed at the same time through different surgical openings or by different surgical approaches, the amount payable will be the allowance for each operation or procedure performed up to an aggregate maximum amount of $300.00.

Separate surgical procedures performed on a patient will be considered to be related unless (1) the later surgical procedure is performed after complete recovery from the sickness or injury causing an earlier surgical procedure, or (2) the later surgical procedure results from causes entirely unrelated to the causes of an earlier surgical procedure.

The total benefit for surgical procedures performed at different times due to the same or related causes will not exceed an aggregate maximum of $300.00, unless the procedures are separated by complete recovery.

Payment for surgical procedures not listed will be made on a proportionate basis, as determined by Planholder, but in no event will the maximum benefit for an unlisted procedure exceed $300.00.

Procedure	Maximum Allowance
Abdomen	
Cutting into abdominal cavity for:	
Stomach, bowel or rectal resection	$300.00
Gastro-enterostomy	225.00
Removal or drainage of gall bladder	225.00
Removal of appendix	150.00
Diagnosis or treatment of organs in abdomen (unless otherwise specified in this Schedule)	150.00
Amputation of	
Thigh: at hip	225.00
other than at hip	187.50
Leg	187.50
Upper arm, forearm, entire hand or foot	150.00
Thumbs, fingers, or toes, each	22.50
Appendix--See Abdomen	
Breast	
Amputation: single	150.00
double	225.00
Cancer- - See Tumors	
Chest	
Thoracoplasty:	
Complete	300.00
Other than complete:	
one stage	187.50
two or more stages	300.00
Transthoracic approach to stomach, diaphragm or esophagus	300.00
Vagotomy	300.00

Removal of lung or portion of lung	300.00
Other cutting into thoracic cavity for diagnosis or treatment (tapping excepted)	75.00
Bronchoscopy or esophagoscopy for drainage, biopsy or removal of foreign body or obstruction	60.00
Induction of artificial pneumothorax:	
Initial	37.50
Refills, each	15.00

Dislocation. Reduction of

Other than by open operation:	
Hip, knee joint (patella or semilunar cartilage excepted), elbow or ankle joint	52.50
Shoulder	45.00
Lower jaw, wrist joint, or collar bone	22.50
Bones of hand or foot (except phalangeal joint)	15.00
By open operation: hip	150.00

For all other open operations, the scheduled limit will be twice the limit shown above for the corresponding reduction of dislocation other than by an open operation.

Ear, Nose and Throat

Fenestration, one or both sides	300.00
Mastoidectomy: one side, simple	150.00
radical	225.00
both sides (simple or radical)	225.00
Laryngectomy	300.00
Removal of tonsils or tonsils and adenoids	45.00
Sinus operation by cutting (puncture of antrum excepted):	
Sinuses (extra nasal approach):	
single	75.00
double	112.50
Sinuses (intra nasal approach):	
single	52.50
double	75.00
Puncture of antrum, one or more (including subsequent irrigations)	22.50
Submucous resection of nasal septum	75.00
Tracheotomy	75.00
Removal of one or more polyp	22.50
Any other operation by cutting, electro-coagulation or electro-desiccation (tapping excepted)	22.50

Endoscopy Diagnostic Examination with or without Biopsy:

Thoracoscopy	75.00
Bronchoscopy, esophagoscopy, gastroscopy, laryngoscopy, or peritoneoscopy	60.00
Cystoscopy	37.50
Proctosigmoidoscopy	22.50

Excision or Fixation by Cutting

Hip or sacroiliac joint	225.00
Shoulder, knee joint, semilunar cartilage, elbow, wrist, ankle joint	150.00
Diseased portion of bone, including curettage (alveolar processes excepted and amputation excepted)	75.00
Exostosis--hand or foot	37.50
Impacted tooth, one excision of:	
Partially unerupted from jawbone:	
Maxilla	18.00
Mandible	30.00
Completely unerupted from jawbone	60.00

(When two or more impacted teeth are excised during the same operative session, the scheduled limit for all such excisions shall be limited to the sum of (a) the largest scheduled limit otherwise applicable to one of the excisions and (b) 50% of the scheduled limit otherwise applicable to each of the other excisions)

Eye

Operation for detached retina	300.00
Removal of cataract	225.00
Any other cutting into the eyeball (through the cornea or sclera)	150.00
Any cutting operation on eye muscles for strabismus	150.00
Removal of eyeball	112.50
Any other cutting operation on eyeball	30.00

Fracture. Treatment of

Thigh, vertebra or vertebrae (coccyx and vertebral processes excepted), or pelvis	112.50
Leg, ankle (Pott's fracture), kneecap, upper arm, elbow	75.00
Jawalveolar processes excepted), skull, collarbone, shoulder blade, forearm, wrist (Colles' fracture)	37.50
Hand, foot or sternum	22.50
Thumbs, fingers, or toes, each	15.00
Nose	15.00
Ribs: three or more	37.50
fewer than three	15.00

(The limits shown above are for simple or multiple fractures. For compound fractures, the scheduled limit will be one and one-half times the limit shown above for the corresponding simple or multiple fractures. For fractures requiring open operations, the scheduled limit will be twice the limit shown above for the corresponding simple or multiple fractures)

Genito-Urinary Tact

Removal of kidney	300.00
Fixation of or cutting into kidney	262.50

Removal of tumors or stones in ureter or bladder:	
By open operation	250.00
By endoscopic means	52.50
Stricture of urethra:	
Open operation	75.00
Intra-urethral cutting operation	37.50
Prostatectomy:	
Open operation (complete procedure)	225.00
Transurethral resection	150.00
Any cutting operation for variocele, hydrocele (tapping excepted), epididymectomy or orchectomy:	
Unilateral	75.00
Bilateral	112.50
Complete removal of uterus, with or without removal of tubes and ovaries	225.00
Cervix amputation	75.00
Dilation and curettage (non-puerperal)	37.50
Conization (complete procedure)	37.50
Electrocauterization (except for removal of polyps)	22.50
Operation for cystocele or rectocele	112.50
Operation for both cystocele and rectocele	187.50
Goitre	
Thyroidectomy, one or more stages, complete procedure	225.00
Removal of benign tumor of thyroid	150.00
Hernia. Cutting Operation for Radical Cure:	
Single hernia	150.00
More than one hernia	187.50
(When the hernia is accompanied by surgical treatment of undescended testes, the scheduled limit will be $37.50 greater than the limit specified above)	
Incision and Drainage (furuncles excepted)	
Requiring Hospital confinement	37.50
Not requiring Hospital confinement	15.00
Joint, Incision into (tapping excepted)	37.50
Ligaments and Tendons	
Cutting or transplant:	
Single	75.00
Multiple	112.50
Suturing of tendon:	
Single	52.50
Multiple	75.00

Mastoid--See Ear. Nose and Throat

Paracentesis. Tapping (other than catheterization)	22.50

Rectum

Cutting operation for prolapsed rectum:	
With abdominal approach	300.00
Without abdominal approach	75.00
Cutting operation or injection treatment for radical cure of hemorrhoids (complete procedure):	
External	37.50
Internal, or external and internal	75.00
Cutting operation for fistula in ano:	
Single	75.00
Multiple	112.50
Cutting operation for fissure	37.50
Removal of one or more polyps	22.50
Any other operation by cutting, electro-coagulation or electro-desiccation	22.50

Skull

Cutting into cranial cavity (trephine excepted)	300.00
Trephine	150.00

Spine or Spinal Cord

Operation for spinal cord tumor	300.00
Operation with removal of portion of vertebra or vertebrae (coccyx and vertebral processes excepted)	225.00
Removal of part or all of coccyx, or of vertebral processes	75.00

Suturing (of traumatic laceration of skin with or without debridement

Four sutures or less	7.50

Tapping--See Paracentesis

Thyroid--See Goitre

Tonsils and Adenoids--See Ear, Nose and Throat

Tumors

Cutting operation for removal of one or more:	
Malignant tumors, except those of face, lip or skin	150.00
Malignant tumors of face, lip, or skin	75.00
Pilonidal or dermoid cysts:	
Requiring Hospital confinement	75.00
Not requiring Hospital confinement	15.00
Other cysts or benign tumors:	
Requiring Hospital confinement	37.50

Not requiring Hospital confinement.....	15.00

Varicose Veins

Cutting operation (complete procedure on all veins):	
One leg.....	75.00
Both legs.....	112.50
Injection treatment, one or both legs (complete procedure)	60.00

B. OBSTETRICAL BENEFITS

The obstetrical benefits described below are available under this Plan up to the maximum allowances listed for each procedure.

Benefits for all Care rendered by a Physician (except anesthesia) in relation to a pregnancy, including prenatal and postnatal Care, shall be determined by the procedure involved in the termination of the pregnancy, as listed below. Such benefits shall be available only if the obstetrical patient is enrolled on the date obstetrical expenses are incurred, except as otherwise provided in this Article VI.

Procedure	Maximum Allowance
Delivery of Child or children.....	75.00
Cesarean section, including delivery.....	150.00
Abdominal operation for extra-uterine pregnancy.....	150.00
Miscarriage including dilation and curettage.....	37.50

C. IN-HOSPITAL MEDICAL BENEFIT

When during a Hospital Admission, no surgical or obstetrical services are rendered, the allowance provided for the fee of the attending physician shall be the amount determined by application of the daily rate specified in item 10 of the Schedule to those days on which the physician personally visits the Participant, which allowance is herein called the in-hospital medical benefit.

Once a Participant undergoes a surgical or obstetrical procedure no in-hospital medical benefits will be available for the day the surgical or obstetrical procedure is performed and all subsequent days during the remainder of the admission.

In-hospital medical benefits will be provided for Care rendered to a newborn Child only if the Child is admitted to the Hospital in its own name for treatment of an abnormal condition.

The maximum total number of days for which in-hospital medical benefits will be provided during any one Period Of Hospital Confinement shall be the number set out in item 10(e) of the Schedule.

D. DIAGNOSTIC AND RADIOLOGICAL AND LABORATORY BENEFITS

When any Participant shall receive diagnostic radiological and laboratory services prescribed by a Physician, while not confined as a bed patient in a Hospital, the amount of benefits for x-ray and laboratory examinations made during any one calendar year shall not exceed the reasonable charge for such services and shall be limited to the amounts specified in items 11(a) and 11(b) of the Schedule.

E. ANESTHESIA BENEFITS

Payment will be made for anesthesia services rendered in connection with a surgical or obstetrical procedure for which a benefit is payable hereunder while the patient is not Hospital confined, provided the anesthesiologist is a Physician other than the operating surgeon or obstetrician in charge. The amount of the anesthetic allowance shall be determined by applying the percentage shown in item 9 of the Schedule to the surgical or obstetrical allowance.

ARTICLE VII. LIMITATIONS AND EXCLUSIONS

The benefits of this Plan are not available for:

A. A Hospital Admission primarily for diagnostic or evaluation procedures;

B. Any services or supplies rendered by a Physician in connection with a routine physical examination, or any diagnosis or evaluation procedures not necessary to the proper treatment of an abnormal physical or mental condition;

C. Any services or supplies furnished by Veterans Administration facilities;

D. Any services or supplies for which benefits are, or could upon proper claim be provided under the worker's compensation law, or any other present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality;

E. Deleted;

F. Care in a health resort, rest home, nursing home, or any institution primarily providing convalescent, rehabilitative or custodial Care;

G. Deleted;

H. Services or supplies rendered to any Dependent Child, after marriage;

I. Any services or supplies rendered to any Participant not eligible for coverage in accordance with the provisions specified herein;

J. Any services or supplies provided during the course of a Hospital Admission that commences before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of his coverage, except as provided in Article V, Section I, of this Plan;

K. Deleted;

L. Care provided by a Hospital to ambulatory patients, on a self-care or minimal services arrangement;

M. Services of special nurses or their room and board;

N. Anesthesia services rendered by the operating surgeon;

O. Deleted;

P. Services rendered through a medical department maintained by the Planholder;

Q. Any services or supplies rendered for dental Care and treatments, dental surgery, or dental appliances, except for (1) Covered Oral Surgery, (2) surgical removal of impacted teeth, or (3) services made necessary by accidental bodily injury effected solely through external means and occurring while the Participant is covered hereunder; provided, however, that this Section Q shall not be applicable to services and supplies rendered to a newborn Child that are necessary for treatment or correction of a congenital defect (this Section Q shall be applicable only to benefits provided under Article VI of this Plan);

R. Deleted;

S. Any services or supplies that are not medically necessary;

T. Any services or supplies not applied for and specified herein as benefits;

U. Eyeglasses, including contact lenses, hearing aids, or examinations for the prescription or fitting thereof, or examinations for the purpose of determining visual acuity or level of hearing;

V. The portion of a charge for a service or supply that is in excess of the reasonable charge as determined by the Planholder;

W. Any services or supplies rendered for treatment of (1) weak, strained, flat unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations or (2) corns, calluses or toenails except for the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease;

X. Blood or blood plasma that is replaced by or for the patient;

Y. Any services or supplies rendered to a Participant for reduction of obesity or weight, including surgical procedures, unless (1) the reduction of obesity or weight is required in connection with treatment for another covered diagnosis, and (2) such reduction is determined to be medically necessary; or

Z. Services or supplies for refractive surgery, for complications arising in any manner from refractive surgery, or for the reperformance, repair, or adjustment of any refractive surgery procedure.

ARTICLE VIII. TERMINATION OF COVERAGE

A. DELETED

B. TERMINATION OF COVERAGE

The coverage of any Retiree and his Dependents included hereunder shall automatically terminate upon:

1. The last day of the last Plan Month for which his contribution is paid;

2. The effective date of an amendment to this Plan that terminates the coverage of any class of Retirees to which he belongs.

3. Upon the death of the Retiree. However, coverage of his surviving Dependents may be continued following the date of death, provided that the surviving spouse or, in the absence of a surviving spouse, the eldest Dependent shall be deemed to be the Retiree for purposes of this Plan, and provided further that their portion of the contribution is paid. Coverage for each of such Dependents shall terminate on the earliest of the following dates:

   a. the last day of the Plan Month in which a Dependent marries or remarries (but this event shall only terminate coverage of the Dependent who is marrying or remarrying and not the coverage of the other Dependents);

   b. as to any Dependent of the Retiree, the last day of the Plan month in which such Dependent ceases to be a Dependent as defined in this Plan;

   c. the last day of the Plan Month in which the Dependent becomes eligible for coverage under any other employer-sponsored policy, Plan or program of group medical coverage; or

d. Upon the date of termination of this Plan.

Coverage under this provision shall be limited to Dependents who were covered at the time of the Retiree's death, except that coverage may also be extended to any newborn natural Child of the deceased Retiree in accordance with the other provisions hereof that relate to newborn children.

C. TERMINATION OF DEPENDENT COVERAGE

The coverage of any Dependent of a Retiree included hereunder shall automatically terminate at the end of the Plan Month in which such Dependent ceases to be a Dependent as defined in this Plan.

D. TERMINATION OF PLAN

The Planholder reserves the right to terminate this Plan at any time. After termination of this Plan benefits payable under this Plan in connection with any claim that arose prior to the date of termination shall be paid in accordance with the terms of this Plan as in existence at the time of termination, subject to the Planholder's allocation of funds to pay such claims.

E. NOTICE OF TERMINATION

Under no circumstances shall the Planholder be obligated to notify any Participant of the termination of this Plan or of his coverage hereunder, other than as provided by law for other legislative actions of the Planholder.

ARTICLE IX. CONVERSION

There is no conversion privilege for this Plan.

ARTICLE X. GENERAL PROVISIONS

A. PLAN; AMENDMENTS

1. This document, including the attached Schedule of Specifications, shall constitute the entire Plan. All statements made by the Retirees covered shall be deemed representations and not warranties, and no statement made by any Retiree covered shall be used in any contest or in defense of a claim hereunder unless a copy of the instrument containing the statement is or has been furnished to such person or to his beneficiary.

2. This Plan may be amended or changed at any time, and from time to time, subject to applicable laws, upon concurrence of the Planholder's Mayor, Director of Finance and Administration and City Attorney without the consent of the Participants. No Amendment shall deprive a Participant of any benefits to which he became entitled in connection with any claim incurred before the date of the Amendment, subject to the Planholder's allocation of funds to pay such claims.

B. INCONTESTABILITY

This Plan shall is incontestable, except for non-payment of contributions.

C. TIME LIMIT ON CERTAIN DEFENSES

No misstatements, except fraudulent misstatements, made in the application for coverage shall be used to void the coverage or to deny a claim for benefits on account of hospitalization and/or medical-surgical services rendered after one year from the date of coverage of the Participant.

D. DELETED

E. NOTICE OF CLAIM

The Retiree shall give or cause to be given written notice to the Planholder or its duly authorized agent within thirty (30) days or as soon as reasonably possible after any Participant receives any of the services for which benefits are provided herein.

F. CLAIM FORMS

The Planholder will furnish to the Retiree, the Hospital, and/or the Participant's Physician, upon receipt of a notice of claim, or prior thereto, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Participant shall be deemed to have complied with the requirements of this Plan as to proof of loss upon submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

G. PROOFS OF LOSS

Written proof of loss must be furnished to the Planholder by the Retiree within ninety (90) days after any Participant hereunder receives services for which benefits are provided herein. Failure to give notice or furnish such proof within the time specified shall not invalidate any rights if it shall be shown not to have been reasonably possible to give such notice or furnish such proof, and that it was done as soon as was reasonably possible, an in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

H. TIME OF PAYMENT OF CLAIMS

Benefits payable under this Plan for any loss will be paid promptly upon receipt of due written proof of such loss. Warrants issued in payment of claims shall be mailed to the address of the claimant as stated on the claim form. If a warrant is returned in the U.S. Mail or is not timely presented for payment by its expiration date, the Planholder and the administrator of the Plan, if any, shall make a reasonable effort to locate the claimant and reissue the warrant. However, the right to claim any benefit hereunder shall terminate and all rights shall revert to the Planholder, unless the claimant contacts the Planholder or the administrator and obtains a replacement warrant within one year from the original date of issuance of the claim warrant.

I. LEGAL ACTIONS

No action at law or in equity (or arbitration proceeding if arbitration is required in lieu of judicial legal action under provisions applicable to this Plan) shall be brought to recover under this Plan unless brought within three years after the date of rendition of the services for which claim is made.

J. INDIVIDUAL CERTIFICATE

The Planholder will issue to each Participant an individual certificate setting forth a statement as to the hospitalization and medical-surgical benefits to which he is entitled and to whom the benefits are payable.

K. GENDER

Use herein of a personal pronoun in the masculine gender shall be deemed to include the feminine, unless the context clearly indicates the contrary.

L. DELETED

M. DISCLAIMER

The Planholder shall not be liable for any act or omission by any Hospital, Physician, their agents or employees, in caring for a Participant receiving services under this Plan.

N. DISCLOSURE AUTHORIZATION

In consideration of the Planholder's having waived physical examination in connection with the application for coverage hereunder, the Retiree, on behalf of himself and his covered Dependents, shall be deemed to have authorized any attending Physician, nurse or Hospital to furnish the Planholder all information and records or copies of records relating to the diagnosis, treatment, or Care of any Participant included under this coverage; and such Participant shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

O. REFUND OF BENEFITS

If and when it shall be determined that benefits have been paid hereunder to which the Participant was not legally entitled, the Retiree or other Participant benefiting thereby upon demand, shall refund such payment to the Planholder. In the event that the benefits are not refunded, then the Planholder may seek recovery at law or in equity or pursue any other rights, including (after notice and a right to be heard on the matter) an offset against any claim or amount payable to the Retiree who is the beneficiary of the error. The right of offset shall extend to any claims and amounts owing to the Retiree under whose coverage the error arose.

P. SUBROGATION

In consideration of benefits provided under this Plan, the Planholder (as the source of payment of benefits under the Plan) shall be subrogated to any recovery (irrespective of whether there is recovery from the third party of the full amount of all claims against the third party) or right to recovery of any Covered Person or legal representative of Participant (individually and collectively referred to as the "Claimant") against any person or entity, including any insurance maintained by such Participant. The Claimant shall cooperate in doing what is reasonably necessary to assist the Planholder in exercising such rights, including but not limited to (i) notifying the Planholder of the institution of any claim against a third party, (ii) notifying the third party and the third party's insurer, if any, of the Planholder's subrogation rights, and (iii) releasing any information to the Planholder that the Planholder determines may assist the Planholder in exercising its subrogation rights. The Claimant shall not do anything after a loss to prejudice such rights.

In its sole discretion, the Planholder reserves the right to prosecute an action in the name of the Claimant against any third party(ies) potentially liable to the Claimant. The Planholder shall have the absolute discretion to settle subrogation claims on any basis it deems warranted and appropriate under the circumstances. If a Claimant initiates a lawsuit against any third parties potentially liable to the Claimant, the Planholder shall not be responsible for any attorney's fees or court costs that may be incurred in such liability claim.

The Planholder shall be entitled, to the extent of any payments made to or on behalf of a Claimant, to be paid first from the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery asserted by or on behalf of a Claimant against any person or entity legally responsible for the injury for which such payment was made. The Planholder shall be reimbursed by the Claimant an amount of money equal to all sums paid by the Planholder under the Plan to or on behalf of the Claimant and all expenses, costs and attorney's fees incurred by the Planholder in connection with the prosecution and collection of its subrogation interest. The right is also hereby given the Planholder to receive directly from any third party(ies), attorney(s) or insurance company(ies) any amount equal to the amount paid to or on behalf of the Claimant.

Amounts recovered in excess of the Planholder's reimbursement and costs shall be paid to the Claimant, but such excess shall apply as a credit against liability of the Plan Sponsor for further payment to or on behalf of the Claimant, which has arisen or may arise from the injury or illness that forms the basis of the claim asserted by or on behalf of the Claimant.

SCHEDULE OF SPECIFICATIONS

Item No.	Hospitalization	All Cases
1	Room allowance	$20.00/day
2	Number of days	120
3	Intensive Care: Hospital Ancillary Coverage: All usual Hospital services, including: 1. Blood and plasma; 2. Anesthesia and its administration when rendered in the Hospital and charged for by a Physician; 3. Ambulance service; 4. Preadmission Testing; 5. Intensive Care and coronary care units; 6. Outpatient. Total benefits per Period Of Hospital Confinement, including bed-patient and Outpatient Care, shall be calculated at 100% of the first $400.00 of eligible charges plus 75% of the next $10,000.00 of such charges. Charges incurred under item 1 of the Schedule are not to be included.	
4	Deductible amount: $500 per Hospital Admission, subject to waiver for precertification.	
5	Non-medical case Deductible amount	xxx
6	Basic hospitalization maximum: Hospital Ancillary Coverage: All usual Hospital services, including: 1. Blood and plasma; 2. Anesthesia and its administration when rendered in the; 3. Hospital and charged for by a Physician; 4. Ambulance service; 5. Preadmission Testing; 6. Intensive Care and coronary care units; 7. Outpatient.	

Total benefits per Period Of Hospital Confinement, including bed-patient and Outpatient Care, shall be calculated at 100% of the first $400.00 of eligible charges plus 75% of the next $10,000.00 of such charges. Charges incurred under item 1 of the Schedule are not to be included.

Medical-Surgical

7	Surgery	$300.00
8	Obstetrics	$300.00
9	Outpatient Anesthesia Outpatient anesthesia and its administration rendered to a Participant, other than in the Hospital, shall be payable at 20% of the surgical or obstetrical allowance.	
10	In-hospital medical:	
	(a) 1st Day	$5.00
	(b) 2nd Day	$5.00
	(c) 3rd Day	$5.00
	(d) 4th and each succeeding Day	$5.00
	(e) Maximum Days	120
11	Diagnostic x-ray and laboratory	
	An amount not to exceed reasonable charge	
	(a) x-ray maximum	$50.00
	(b) Laboratory maximum	$50.00
121	Radiation therapy	xxx
13	Emergency first-aid maximum	xxx
14	Assistant surgeon	xxx

Accidental Injury (covered)

15	Accidental Injury Hospital room limit	N.L.
16	Maximum per injury	$300.00

N.L. in any space means "No Limit"
xxx in any space means
Coverage Factor inapplicable or Not Covered

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you have recently become covered under your Employer's group health **plan** (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. Contact your Employer to determine if you are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage,
- When it may become available to you and your family, and
- What you need to do to protect the right to receive it.

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either contact the Plan Administrator or review the Benefit Booklet or Certificate of Coverage provided to you by your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact your Plan Administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a 'qualifying event.' Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a 'qualified beneficiary.' A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact your Employer and/or COBRA Administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a 'dependent child.'

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage *may* last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A dependent child losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Administrator.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

EXHIBIT B

Administrative Charges

1. Fixed Administrative Charge:

   (a) For the period May 1, 2006 through April 30, 2007, the Plan Sponsor, upon receipt of the Administrator's invoice, shall pay to the Administrator an amount equal to $17.43 per Subscriber only unit, $42.02 per Subscriber plus one Dependent and $55.26 per Subscriber plus two or more Dependents (the "Fixed Administrative Charge").

   (b) For Retirees' Hospitalization and Medical-Surgical Program, for the period May 1, 2006 through April 30, 2007, the Plan Sponsor, upon receipt of the Administrator's invoice, shall pay to the Administrator an amount equal to $20.97 for each Subscriber only unit, $50.86 for each Subscriber plus one Dependent, $66.96 for each Subscriber plus two or more Dependents (the "Fixed Administrative Charge.")

   (c) The Fixed Administrative Charge shall be invoiced and paid in accordance with the terms of Addendum B.

2. Fee-For-Service Medical Charges:

   (a) The Administrator will charge the Plan Sponsor its gross fee-for-service costs for Covered Services rendered to Participants.

   The Administrator will charge the Plan Sponsor for payments to Health Care Providers made on behalf of Plan Sponsor for Covered Services rendered to Participants. For In-Network Health Care Providers, such payments will be based on the contract rate in the BlueChoice PPO contract between such provider and the Administrator or the applicable Blue Cross and/or Blue Shield Plan. For other Health Care Providers, such payments will be based on the allowable amount for the services in question, as determined by Administrator or the applicable Blue Cross and/or Blue Shield Plan.

Fee-For-Service Medical Charges will be paid to Health Care Providers by the Administrator as provided in Article VIII of the Agreement.

3. Charges for Additional Services

Third Party Reimbursement.....25.0% of any recovered amounts*
BlueCard® Program/Network access fees ..... The lesser of 10.0% of the discount or $2,000 per claim

BlueCard® Worldwide Program
International Group (10 or more member living outside of the USA)..... No additional charge
Domestic Group (under 10 members living outside of the USA).....No additional charge
Optional Services for International or Domestic Group .....No additional charge

*The indicated reimbursement fees are based on the net recovery after attorney's fees, if any, have been paid.

4. The **Prescription Drug Program Rebate Credit** is $12.60 per contract per month for the first contract year May 1, 2006 through April 30, 2007. Expected rebate amounts to be received by Blue Cross and Blue Shield of Texas are passed back to our accounts with one hundred percent of the amount applied as a credit on the monthly billing statement on a per contract per month basis. The rebate credits are paid prospectively to the account. The rebate credit does change each year and is based on the expected rebates to be received by BCBSTX based on the City of Houston's group specific utilization. For the second contract year, third contract year, first optional contract year and second optional contract year the Prescription Drug Rebate Credit will be calculated based on the RX Rebate Calculation listed in Exhibit F as part of the Quarterly Renewal reports. Additional information concerning this rebate credit is included in **Addendum A.**

BlueChoice® Network Service Area

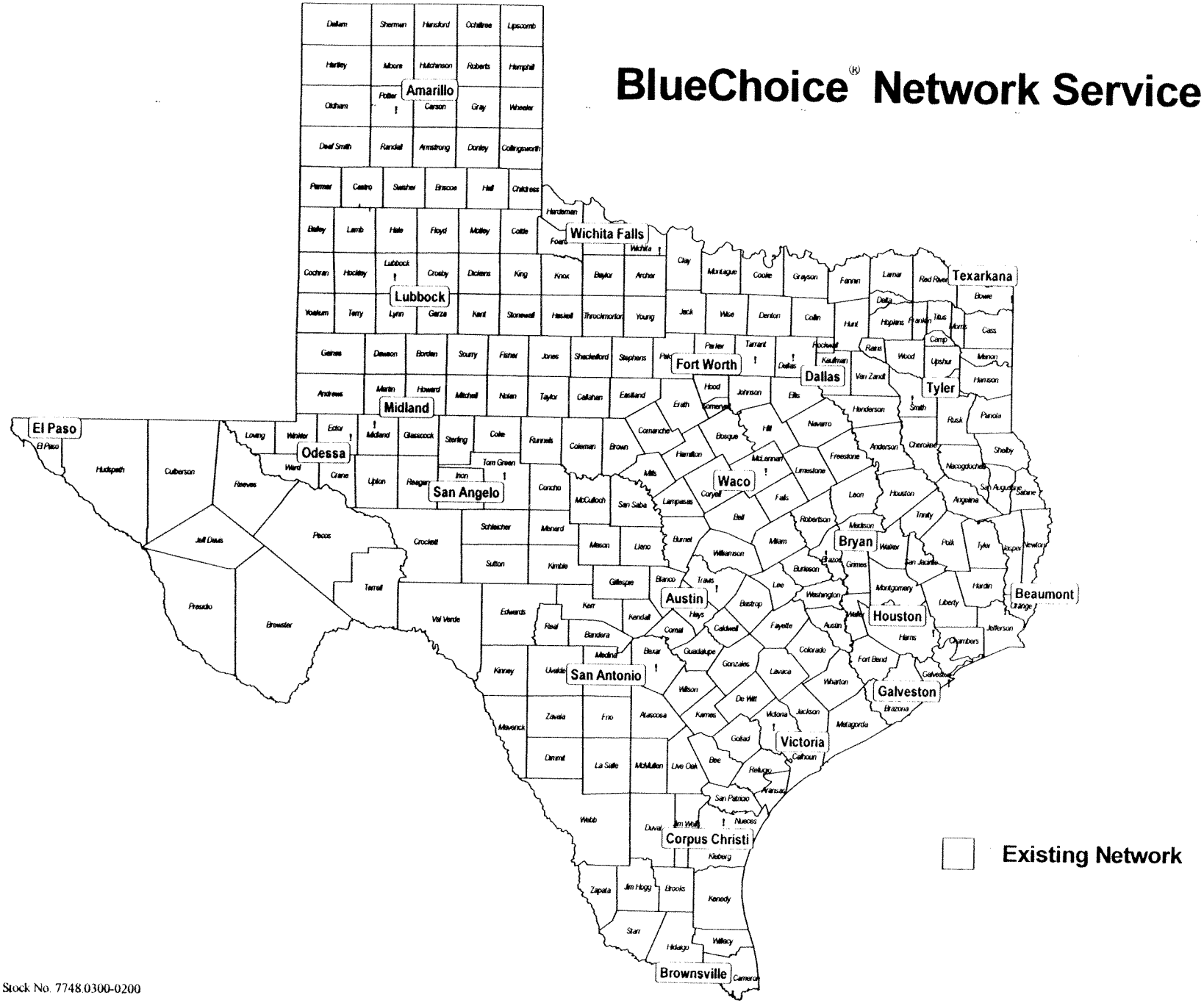

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EXHIBIT E

SERVICE PERFORMANCE STANDARDS

The Service Performance Standards described herein shall apply to the Preferred Provider Organization (PPO) Administrative Agreement (the Agreement) between Administrator and Plan Sponsor to which this Exhibit E is attached. Administrator will not be obligated to satisfy any provision of this Exhibit E if enrollment in the Plan medical benefit coverage administered by Administrator is less than 1,000 Employees/Retirees. In the event that PPO enrollment drops to 850 Employees/Retirees or fewer, Administrator will withdraw the performance standards on the PPO, and will apply amounts at risk from the PPO standards to the HMO, increasing the amount at risk for the HMO standards to $1 million.

The Service Performance Standards set out in this Exhibit E are limited solely to the medical benefit coverage under the Plan and do not include prescription drug, dental, vision, life, accidental death and disability coverage, or services, if applicable, under the medical management programs provided by Administrator when elected by the Plan Sponsor.

SECTION I
DEFINITIONS

Abandoned Calls means all Participant calls that reach Administrator and are placed in queue to the City of Houston dedicated service line but have not reached their final destination. The call becomes an *Abandoned Call* when it is terminated because the Participant intentionally ends the call before a customer service representative becomes available. Any calls abandoned or terminated by the caller prior to the Average Speed to Answer number of seconds standard will not be counted as *Abandoned Calls*.

Average Speed to Answer or Wait Time in Queue means the time the Participant spends on hold after being placed in queue to the City of Houston dedicated service line.

Claim Financial Accuracy means the accuracy of dollars paid in accordance with the provisions of the Employer's medical benefit coverage administered by Administrator.

Claim Processing Accuracy means the accuracy rate achieved by the Administrator in adjudicating claims in accordance with the provisions of the Employer's medical benefit coverage administered by Administrator.

Claim Turnaround Time means the processing time for *Measurable Claims*.

Measurable Claims means notification on a form acceptable to Administrator that a service has been rendered or furnished to a Participant in accordance with the provisions of the Plan Sponsor's medical benefit coverage in effect on the date a service is rendered or furnished. This notification must set forth the full details of such service including, but not limited to, the Participant's name, age, sex, Subscriber identification number and group number. Notification must also provide the name and address of the provider of service, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis, and the fee for such service.

Such claim is *measurable* if, when received by Administrator, it contains all of the information required to process the claim. If any additional information is required to process the claim, including medical records or supporting documentation, the claim is not considered a Measurable *Claim.*

Settlement Period means the period for which Administrator's service performance will be measured, as set forth in Addendum E-1.

SECTION II
SERVICE PERFORMANCE STANDARDS

2.01 The Service Performance Standards set out in this Exhibit E and Addendum E-1 are limited solely to Fee-for-Service Medical Charges for claims administered directly by Administrator. Service Performance Standards do not apply to Fixed Medical Charges administered by Administrator.

2.02 The Service Performance Standards set out in this Exhibit E and Addendum E-1 are limited solely to the PPO medical benefit coverage under the Plan and do not include prescription drug, dental, vision, life, accidental death and disability coverage.

2.03 All obligations, terms, conditions, promises, agreements, and language in the Agreement apply equally to the obligations, terms, conditions, promises, agreements, and language in this Exhibit E and Addendum E-1.

SECTION III
CALCULATION

3.01 In measuring Administrator's performance of administrative duties, percentage levels of performance will be rounded to the nearest tenth of one percent.

3.02 All measurement and calculation methods used in determining performance results are in accordance with the Blue Cross and Blue Shield Association performance reporting guidelines and/or administrator's corporate policies. Highlights of those guidelines are as follows:

Abandoned Call

The telephone abandonment rate is measured by dividing the total number of *Abandoned Calls*, as defined, by the total number of calls accepted. Call totals are provided by telephone reports, which capture the number of calls accepted and abandoned. The standard is measured using Participant calls.

Average Speed to Answer

The *Average Speed to Answer* is the telephone response time that is measured from the time calls are put in queue until they reach their final destination and are answered by a customer service representative. The *Average Speed to Answer* is provided by telephone reports, which compute the average number of seconds that Participants spend on hold waiting for their call to be answered. The standard is measured using Participant calls on a group-specific basis.

Claim Financial Accuracy

Claim Financial Accuracy is determined from an audit of randomly selected claims. *Claim Financial Accuracy* is computed by summing the overpayments and the underpayments (*absolute value*) and dividing by the total population of dollars that should have been paid (total population dollars paid plus underpayments minus overpayments). The end result is subtracted from one for the accuracy rate. The results incorporate statistically valid samples.

Claim Processing Accuracy

Claim Processing Accuracy is determined from an audit of randomly selected claims. The *Claim Processing Accuracy* percentage is calculated dividing the number of accurately processed claims by the number of claims selected in the sample. All claim data fields are reviewed; however, only errors resulting in a payment error (overpayment or underpayment) are counted as processing errors. Also included are misapplied deductibles and co-share amounts.

Claims excluded as errors are claims with administrative inaccuracies that do not impact claims disposition, future claims disposition, or customer reporting.

Claim Turnaround Time

The Claim Turnaround Time is the processing time for Measurable Claims and is measured from the time the claims are received in an Administrator office to the finalization date. The number of days during which claims are held for any reason beyond the control of Administrator (for example, if Administrator is waitin g on the Plan Sponsor to provide membership and eligibility information) is excluded from the processing cycle time.

Member Satisfaction

The percent of member satisfaction will be measured based on all respondents to the Administrator's Continuous Tracking Study who rate the overall performance of Administrator as Excellent, Very Good, or Good. The Continuous Tracking Study assesses Administrator performance on all aspects of a customer's experience with their health plan, including medical quality, claims and customer service, and Administrator communications.

SECTION IV TIMING

4.01 The Service Performance Standards in this Agreement shall be measured on an annual basis for the settlement period in Addendum E-1.

4.02 Unless stated otherwise in this SECTION IV, the only period in which Administrator's performance of administrative duties will be measured and for which the Plan Sponsor may receive a refund is on an annual basis.

4.03 Any claims incurred before May 1, 2004 and any inquiries related to such claims will be excluded from the measurement of Administrator's performance of administrative duties and the Plan Sponsor's refund based thereon for the settlement period set forth in Addendum E-1.

4.04 For measurement of the Service Performance Standards to continue, the bank account must remain appropriately funded and all Fixed Administrative Charges must be received by Administrator in accordance with the terms detailed in the Agreement.

4.05 If for any reason the Agreement is terminated prior to the end of the Settlement Period or enrollment in the PPO coverage administered by Administrator falls below 1,000 Employees/Retirees, Administrator's performance of administrative duties will not be measured and the Plan Sponsor will not receive any refund, based on that part of the Settlement Period in which the Agreement was in effect.

SECTION V DETERMINATION

5.01 Administrator will measure its performance of administrative duties and report the measurements in accordance with this Exhibit E and Addendum E-1 to Plan Sponsor within ninety (90) days following the end of each Settlement Period. Administrator shall refund to the Plan Sponsor any amounts due in accordance with this Exhibit E and Addendum E-1 in the form of a reduction of the Fixed Administrative Charge, in 12 equal monthly installments over the subsequent 12 month period following the applicable Settlement Period. However, if the Agreement has been terminated or is at the end of its term, Administrator will repay the amount in a lump sum within five (5) months following the end of the applicable Settlement Period.

5.02 Administrator will be obligated to measure its performance of administrative duties but will not be obligated to refund the Plan Sponsor based thereon until the Agreement has been executed and is on file with Administrator.

5.03 Administrator will not be obligated to measure its performance of administrative duties and will not be obligated to refund the Plan Sponsor based thereon for any portion of Settlement Period in which the Plan Sponsor:

a. Fails to provide Administrator with timely changes in enrollment or membership information or any other reports or information as may be necessary for Administrator to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan, or

b. Fails to comply with all established banking procedures, or

c. Fails to pay Fixed Administrative Charges in accordance with the terms in the Agreement.

5.04 If for any reason there is a significant change in the benefit structure or the administrative procedures of the medical benefit coverage administered by Administrator during any Settlement Period, Administrator reserves the right to modify the level of performance and/or the Fixed Administrative Charges at risk in this Exhibit E and Addendum E-1.

5.05 Administrator will not be obligated to measure any Service Performance Standard impacted by changes requested in writing by the Plan Sponsor during the time period required to modify the Administrator system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or amendments to the Plan must be submitted to Administrator in accordance with the notice provisions of the Agreement.

5.06 If either party desires to utilize an outside auditing firm to perform an audit, both parties must mutually agree as to the selection of such audit firm. The audit will be performed at the expense of whichever party has requested the outside auditing firm. If the Administrator does not approve the outside auditing firm requested by the Plan Sponsor, the Administrator may elect to require the Plan Sponsor to use the Administrator's designated Public Accounting firm to perform the audit at the Plan Sponsor's expense. All such audits by outside auditing firms shall be subject to the Administrator's external review procedures and guidelines in existence at the time such audit is performed, a copy of which shall be furnished to the Plan Sponsor, upon request, prior to the commencement of any audit.

ADDENDUM E-1

Service Performance Standards will only apply if a minimum of 1,000 covered Employees/Retirees are enrolled in the PPO plan administered by Blue Cross Blue Shield of Texas (BCBSTX) for City of Houston Employees and Retirees. Measurement of each standard shall be based on information and data that is City of Houston group specific, unless otherwise noted. Service Performance Standards exclude measurement of out-of-network claims activity.

Service Performance Standards and at risk amounts shall be applicable during each of the following Settlement Periods:

Initial Term: May 1, 2006 – April 30, 2009
First Optional Renewal Period: May 1, 2009 – April 30, 2010
Second Optional Renewal Period: May 1, 2010 – April 30, 2011

Service Performance Standards are contingent upon the reporting of membership changes, payment of administrative charges in accordance with the provisions detailed in the Agreement, and adherence to the funding requirements as detailed in Addendum B of the Agreement. Refer to the Service Performance Standards Exhibit E for detailed information.

Service	Definition	Level of Performance	At Risk
1. PARTICIPANT SATISFACTION			
1. Participant Satisfaction	BCBSTX will receive member satisfaction rating based on responses to the Continuous Tracking Study. The percent satisfied will be measured based on all City of Houston respondents who rate the overall performance of BCBSTX as Excellent, Very Good, or Good. The Continuous Tracking Study measures member satisfaction on all aspects of a customer's experience with their health plan including medical quality, claims and customer service, and plan communication.	85% - 100% 80.0% - 84.9% 0% - 79.9%	0
2. CLAIM PROCESSING			
	Claim accuracy will be determined from a randomly selected claims sample audited by BCBSTX. The audit will be validated by BCBSTX Internal Audit or may be performed by BCBSTX Internal Audit. City of Houston may verify BCBSTX results through an independent auditor contracted and paid for by City of Houston.		
2A. Claim Processing Accuracy	Processing Accuracy is defined as the percent of claims processed accurately.	95.0%-100% 0%-94.9%	0 $7,000
2B. Claim Financial Accuracy	Financial Accuracy is defined as the percent of dollars paid accurately.	97% - 100% 94%% - 96.9% 0% - 93.9%	0 $3,500 $7,000
2C. Claim Turnaround Time	Turnaround Time is defined as the number of days it takes to process a City of Houston claim, beginning with the date the claim is received to the finalization date. The standard is measured as a percent of process-ready claims finalized within 14 calendar days. Process-ready claims are defined as claims that contain all information required to process the claim.	90% - 100% 0%-89.9%	0 $7,000

3. CUSTOMER SERVICE			
3A. Average Speed to Answer	Average Speed To Answer, calculated over the complete workday, is defined as the time a caller spends on hold until a service representative becomes available. The standard is measured by determining the average number of seconds the caller spends waiting for calls placed to the dedicated City of Houston service line. Performance will be measured by BCBSTX based on all BCBSTX business serviced at the Houston office.	0-30 seconds 30.1 or more seconds	0 $5,250
3B. Abandoned Calls	Abandoned Calls are defined as calls, calculated over the complete workday, that reach the facility and are placed in a queue to the City of Houston dedicated service line, but are not answered because the caller hangs up before a service representative becomes available. Any calls abandoned or terminated by the caller prior to the Average Speed of Answer number of seconds standard will not be counted as Abandoned Calls. Performance will be measured by BCBSTX based on all BCBSTX business serviced at the Houston office.	0%-5.0% 5.1%-100%	0 $5,250
4. ID CARDS			
4. ID CARDS	Initial issuance of standard medical ID cards will be mailed prior to effective date of May 1, 2006 or within 20 business days if electronic eligibility data is received after Monday, April 3, 2006. Electronic eligibility data must be complete and accurate. Measurement is based on the BlueSTAR ID Card Statistical Report.	Met Not Met	0 $7,000
5. ACCOUNT MANAGMENT			
5. Account Management	Account Management will be measured by the group using the HCSC Account Management Report Card. Performance will be measured in the following areas: 1 – Provides effective support in preparing for, and conducting open enrollment events/sessions. 2 – Provides client with timely notification of issues impacting members. 3 – Responds to issues and questions in a timely and comprehensive manner. 4 – Develops and follows through on action plans; effective coordination to resolve open issues. 5 – Is accessible and attends scheduled meetings. 6 – delivers agreed upon reports and communication of program results in a timely manner.	Goal Met Goal Not Met	0 $7,000
Total at Risk			$45,500

The foregoing is subject to all of the following terms and conditions:

1. The aforementioned total amount at-risk under the service standards is applicable if BCBSTX is selected by the City of Houston as the sole PPO carrier.

2. BCBSTX performance under the service performance standards will be reported by BCBSTX at the end of each year, within 90 days after the end of the applicable Settlement Period. Performance under each standard will be considered separately.

3. If BCBSTX is found to be in material breach of a standard, BCBSTX agrees to repay the amount at risk that is allocated to that standard, in the form of an Administrative Fee reduction, in 12 equal monthly installments over the 12-month subsequent period. However, if the agreement has been terminated or is at the end of its term, BCBSTX will repay the amount in a lump sum.

4. Repayment of the amounts specified herein shall not be the City of Houston's sole remedy in the event that BCBSTX materially breaches one or more of the service standards and shall not prejudice the City against termination for cause as provided for in the Agreement.

5. All performance results calculated as a percentage will be rounded to the nearest one-tenth ($1/10^{th}$) of 1 percent. If the second decimal numeral is five (5) or greater, then the first decimal numeral will increase by 1. If the second decimal numeral is four (4) or less, the first decimal numeral shall remain unchanged.
for example:

0.25 shall be rounded to 0.3; and
0.24 shall be rounded to 0.2

Exhibit F

PPO

MANAGEMENT REPORTS

1. Executive Summary
2. Total Enrollment by Member Relationship
3. Total Enrollment by Plan Graph
4. Enrollment by Participant Category Graph
5. Enrollment by Member Relationship and Gender Graph
6. Health Benefits Paid by Member Age Graph
7. Total Medical Benefits Paid Graph
8. Health Payments by Subscriber, Spouse, Child
9. PPO In Network vs. Out of Network Payments
10. Utilization Overview
11. Inpatient Utilization Statistics Graph
12. Inpatient Utilization by Year Graph
13. PPO Inpatient Hospital Utilization Graph (In-network vs. Out-of-Network)
14. Inpatient Average Length of Stay Graph
15. Cost Summary
16. Total Payments by Group and Section
17. Top 10 Hospitals Ranked by Inpatient Benefits Paid
18. Top Claimants Over $25,000
19. Top 25 Primary Diagnoses Based on Health Benefits Paid
20. Benefits Paid by Diagnosis Categories
21. Admissions Per 1000 Members by Diagnostic Category Graph
22. Prescription Drug Claims Summary
23. Top 25 Prescription Drugs
24. Average Prescription Drug Cost Graph
25. Prescription Drug Generic Fill Rate Graph
26. Top 10 Prescription Drug Graph
27. Standard Subrogation Reports
28. Claims by Actives, Retirees under 65, Retirees over 65 not eligible for Medicare, Retirees over 65 eligible for Medicare.
29. Blue Care Connections Quarterly Reports, to include the following reports Predictive Modeling , Disease Management, Case Management, Special Beginnings, 24/7 Nurse line, Blue Care Advisors, Personal Health Manager, Health Risk Assessment.
30. Quarterly Renewal, to include 12/15 Report (includes Contracts, FFS claims, Capitation, Prescription Drug Claims), Large Claim Report, RX Rebate Calculation, IBNR Adjustment, Trend Development, Benefit Adjustment, Demographic Adjustment, Provider Contract Adjustment

In addition, BCBSTX can devise and develop various Management Reports as requested by the Group.

EXHIBIT G

Rates and Guarantees
From May 1, 2006 through April 30, 2007
PPO Plan

(All figures are on a 12/15 basis shown as monthly rates)

Monthly Specific Attachment	110%
Maximum Lifetime Reimbursement per Person	$1,200,000
Maximum Aggregate Stop-Loss Benefit for Policy Period	$2,000,000
Specific Deductible for each Person	$ 300,000
Minimum Annual Aggregate Stop Loss Attachment Point (For the period May 1, 2006– April 30, 2007.)	$11,616,340

Monthly Claim Liability Factors:

Effective From: May 1, 2006 through April 30, 2007

All Participants (excluding Plan A Participants):

Employee only	$489.81
Employee plus one dependent	$1,180.92
Employee plus two or more dependents	$1,553.13

1. The claim liability factors shown above are guaranteed for the Contract term (May 1, 2006 through April 30, 2007). Quarterly Renewal calculations with the supporting data reports listed in Exhibit F shall be provided by BCBSTX to the group. The trend factor used in the calculation of the claim liability shall be the current trend factor used for the Houston area for the BCBSTX PPO and prescription drug products.

2. For the second contract year May 1, 2007 through April 30, 2008 the determination of the claim liability shall be based on the actually experienced annual percentage increase in cost under the plan.

   The computation of the Group's actually experienced annual percentage increase shall be prepared in accordance with the renewal calculation methodology established in Exhibit M. The renewal calculation will utilize the Group's claims incurred October 1, 2005 through September 30, 2006 (12 months) paid October 1, 2005 through December 31, 2006 (15 months). The renewal calculation will be prepared by BCBSTX and presented to Group prior to February 1, 2007. Claims used for the purposes of these calculations shall be adjusted to reflect benefit changes, where appropriate. The renewal calculation shall be subject to review by the Group. Available supporting data reports shall be provided by the BCBSTX to the Group to assist in this review. Quarterly Renewal calculations with the supporting data reports listed in Exhibit F shall be provided by BCBSTX to the Group to assist in this review. The trend factor used in the calculation of the claim liability shall be the current trend factor used for the Houston area for the BCBSTX's PPO and prescription drug products.

3. For the third contract year (May 1, 2008 through April 30, 2009) determination of the claim liability shall be based on the actually experienced annual percentage increase in cost under the plan.
In the third contract year the claim liability will in fact be calculated based on the expectations of the cost in the third contract year. Those expectations will be primarily based on the Group's prior medical cost experience projected forward through April 30, 2009. There can be adjustments for things such as demographic or plan design changes. The claim liability formula is included in Exhibit M.

   The computation of the Group's actually experienced annual percentage increase shall be prepared in accordance with the renewal calculation methodology established in Exhibit M. The renewal calculation will utilize the Group's claims incurred May 1, 2006 through April 30, 2007 (12 months) paid May 1, 2006 through July 31, 2007 (15 months). The renewal calculation will be prepared by BCBSTX and presented to Group prior to September 1, 2007. Claims used for the purposes of these calculations shall be adjusted to reflect benefit changes, where appropriate. The renewal calculation shall be subject to review by the Group. Quarterly Renewal calculations with the supporting data reports listed in Exhibit F shall be provided by BCBSTX to the Group to assist in this review. The trend factor used in the calculation of the claim liability shall be the current trend factor used for the Houston area for the BCBSTX's PPO and prescription drug products.

4. For the first optional contract year(May 1, 2009 through April 30, 2010)

   The contract shall expire on April 30, 2009 unless the Group's Human Resources Director notifies BCBSTX in writing of the Group's intent to extend the first optional contract year on or before November 1, 2008, or unless an agreement to extend is made by the date provided.

   The computation of the Group's actually experienced annual percentage increase shall be prepared in accordance with the renewal calculation methodology established in Exhibit M. The renewal calculation will utilize with Group's claims incurred May 1, 2007 through April 30, 2008 (12 months) paid May 1, 2007 through July 31, 2008 (15 months). The renewal calculation will be prepared by BCBSTX and presented to Group prior to September 1, 2008. Claims used for the purposes of these calculations shall be adjusted to reflect benefit changes, where appropriate. The renewal calculation shall be subject to review by the Group. Quarterly Renewal calculations with the supporting data reports listed in Exhibit F shall be provided by BCBSTX to the Group to assist in this review. The trend factor used in the calculation of the claim liability shall be the current trend factor used for the Houston area for the BCBSTX's PPO and prescription drug products.

5. For the second optional contract year(May 1, 2010 through April 30, 2011)

   The contract shall expire on April 30, 2010 unless the Group's Human Resources Director notifies BCBSTX in writing of the Group's intent to extend the first optional contract year on or before November 1, 2009, or unless an agreement to extend is made by the date provided.

   The computation of the Group's actually experienced annual percentage increase shall be prepared in accordance with the renewal calculation methodology established in Exhibit M. The renewal calculation will utilize with Group's claims incurred May 1, 2008 through April 30, 2009 (12 months) paid May 1, 2008 through July 31, 2009 (15 months). The renewal calculation will be prepared by BCBSTX and presented to Group prior to September 1, 2009. Claims used for the purposes of these calculations shall be adjusted to reflect benefit changes, where appropriate. The renewal calculation shall be subject to review by the Group. Quarterly Renewal calculations with the supporting data reports listed in Exhibit F shall be provided by BCBSTX to the Group to assist in this review. The trend factor used in the calculation of the claim liability shall be the current trend factor used for the Houston area for the BCBSTX's PPO and prescription drug products.

EXHIBIT G

Total Fixed Costs:
(The sum of Fixed Administrative Charges plus Specific Stop Loss Premium plus Aggregate Stop Loss Premium)

Effective From: May 1, 2006 through April 30, 2007

All Participants (excluding Plan A Participants):

Monthly Medical Administrative Charges	
Employee only	$21.18
Employee and one dependent	$51.07
Employee and two or more dependents	$67.17
Monthly BlueCare Connection Charges	
Employee only	$1.84
Employee and one dependent	$4.43
Employee and two or more dependents	$5.82
Monthly Prescription Drug Administrative Charges	
Employee only	$2.12
Employee and one dependent	$5.11
Employee and two or more dependents	$6.72
Monthly Prescription Drug Rebate Credit	
Employee only	-$7.71
Employee and one dependent	-$18.59
Employee and two or more dependents	-$24.45
Monthly Fixed Administrative Charges (Net of Prescription Rebate)	
Employee only	$17.43
Employee and one dependent	$42.02
Employee and two or more dependents	$55.26
Monthly Specific Stop Loss Premium Rates	
Employee only	$6.31
Employee plus one dependent	$15.21
Employee plus two or more dependents	$20.01
Monthly Aggregate Stop Loss Premium Rates	
Employee only	$13.95
Employee plus one dependent	$33.63
Employee plus two or more dependents	$44.24
Monthly Total Fixed Costs	
Employee only	$37.69
Employee plus one dependent	$90.86
Employee plus two or more dependents	$119.51

Plan A Participants:

Monthly Fixed Administrative Charges	
Employee only	$20.97
Employee plus one dependent	$50.86
Employee plus two or more dependents	$66.96

1. The Total Fixed Costs shown above are guaranteed for the Contract term (May 1, 2006 through April 30, 2007).

2. For the second and third contract years and the first and second optional contract years the Medical Administration cost, BlueCare Connection and Prescription Drug Costs will not increase more than five (5%) from the previous plan year. Specific stop loss premium rates, aggregate stop loss premium rates and Prescription Drug Rebate Credit will be recalculated each plan year. Specific stop loss premium rates and aggregate stop loss premium rates will be calculated in the same manner as is used for BCBSTX stop loss products in the Houston area.

3. Premiums and Fees for Participants whose coverage is effective on a day other than the first day of a month or whose coverage terminates on a day other than the last day of a month shall be adjusted as indicated below.

   A. If participation is effective from the 1st through the 15th of the month, inclusive, the Premium and Fees for the whole month is due. If participation is effective from the 16th through the 31st of the month, inclusive, no Premium nor Fee is due for the first half of the month during which participation commences.

   B. If participation terminates from the 1st through the 15th of the month, inclusive, no Premium nor Fee is due for the second half of that month. If participation terminates from the 16th through the 31st of the month, inclusive, the Premium and Fee for the whole month is due.

BlueCross BlueShield
of Texas

EXHIBIT H

STOP-LOSS POLICY

(the Policy)

between

BLUE CROSS AND BLUE SHIELD OF TEXAS
(BCBSTX)

and

CITY OF HOUSTON
(Policyholder/Employer)

Group Number: 69184, 70883, 70885

Effective Date: May 1, 2006

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

STOP-LOSS POLICY

Table of Contents

THIS STOP-LOSS POLICY (the Policy) is made and entered into as of the Effective Date indicated on the cover page of this Policy and is by and between **Blue Cross and Blue Shield of Texas** (referred to as BCBSTX) and **City of Houston** (referred to as Policyholder).

The Policyholder understands the liability assumed under the portion of the self-funded employee health and welfare benefit plan (the Plan) which he is self-insuring and further understands that it is exempted from Chapter 101 of the *Texas Insurance Code* only if a qualified employee benefit plan has been filed and meets the requirements of Employee Retirement Income Security Act of 1974, as amended, (ERISA) unless the Policyholder is exempt from requirements of ERISA.

[redacted]

RECITALS

WHEREAS, the Policyholder has established a self-funded employee health and welfare benefit plan (the "Plan") for certain of its Participants; and

WHEREAS, the Policyholder desires to engage BCBSTX to provide stop-loss insurance services to the Policyholder as described below,

NOW THEREFORE, the parties agree as follows:

[redacted]

SECTION I
DEFINITIONS

1.01 **Claim Liability** means the total amount of Paid Claims that the Policyholder is responsible for paying each Policy Period. Claim Liability will be calculated for each Policy Period in accordance with the formula indicated in Item Three of the most current Exhibit to this Policy.

1.02 **Effective Date** means the date shown on the cover page of this Policy.

1.03 **Exhibit** means the attached specifications setting out certain particulars of this Policy or any other subsequent set of specifications supplied by BCBSTX as a replacement Exhibit. The specifications or items of the Exhibit shall be applicable for the Policy Period indicated in the Exhibit, except that any item of the Exhibit may be changed in accordance with the provisions described in SECTION I – DEFINITIONS, 1.15 of this Policy.

1.04 **Final Policy Period** means the period of time beginning on the date shown in Item One of the most current Exhibit and ending on the date the Policy is terminated.

1.05 **Month** means each succeeding calendar Month period beginning on the Effective Date of this Policy.

1.06 **Paid Claims** means the total of all benefits payable under the benefit provisions indicated applicable in Items Four-A.1. and Four-B.1. of the most current Exhibit to this Policy which were paid (in accordance with Addendum B – Transfer Payment and Other Financial Responsibilities) under the terms of this Policy during the Policy Period involved. Paid Claims

may also include payments made under Valid Claims, as the term is defined in the Administrative Services Agreement. *Paid Claims* shall not include:

a. Claims incurred prior to the original Effective Date of this Policy; or

b. Claims incurred after the termination date of this Policy; or

c. Extra contractual damages of any nature, compensatory damages, or any similar damages however assessed, or any payments made as an exception to the Plan or as settlement of a lawsuit; or

d. Any payments made at the specific written request of the Policyholder when not provided for as benefits under the Plan or which are limited or excluded under such document; or

e. Any payments of benefits which are interpreted by the Policyholder as coming within the terms of the Plan if BCBSTX notifies the Policyholder that it does not agree with that interpretation.

1.07 **Participant** means an individual employee, dependent(s) of an employee, a retired employee, dependent(s) of a retired employee, and certain continued persons and their dependents covered under a continuation of coverage provision, whose coverage has become effective in accordance with the terms of the Policyholder's health benefit Plan.

1.08 **Plan** means a program of health and welfare benefits established by an Employer for the benefit of its Participants whether the plan is subject to the rules and regulations of ERISA or for government and/or church plans, where compliance is voluntary.

1.09 **Point of Attachment** means the dollar amount above which stop-loss insurance will apply as indicated in Item Four-A.2., Item Four-A.3, and/or Item Four-B.2. of the most current Exhibit to this Policy.

1.10 **Policyholder**, as used in this Policy, is the Employer.

1.11 **Policy Period** means the twelve (12) month period of time beginning and ending on the dates shown in Item One of the most current Exhibit.

1.12 **Records** means a Participant's medical, financial, or personal data (including patient-specific diagnoses) or data that enables one to derive such Participant's medical, financial, or personal data.

1.13 **Settlement Period** means the twelve-month period beginning and ending on the dates shown in Item One of the most current Exhibit plus the three-Month period immediately following.

1.14 **Stop-Loss Claims** means the amount of Paid Claims for which BCBSTX assumes responsibility and risk for payment.

a. If, during any Month occurring within a Policy Period, Paid Claims for any Participant exceed the amount indicated in Item Four-A.2. and/or Item Four-A.3. of the most

current Exhibit to this Policy, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Policy as **Individual (Specific) Stop-Loss Claims.**

b. Individual (Specific) Stop-Loss Insurance does not extend beyond the termination date of this Policy.

c. If, during any Policy Period, Paid Claims during that Policy Period, less Individual (Specific) Stop-Loss Claims, if any, exceed the Point of Attachment indicated in Item Four-B.2. of the most current Exhibit to this Policy, such excess, if any, shall be referred to in this Policy as **Aggregate Stop-Loss Claims.**

1.15 **Stop-Loss Premium** means the Monthly consideration, calculated in accordance with the formulas indicated in Item Two-A and Item Two-B of the most current Exhibit to this Policy, that is required by BCBSTX for the risk assumed for the Stop-Loss Insurance indicated in Item Four-A and Item Four-B of the most current Exhibit to this Policy. The Policyholder shall pay to BCBSTX the Stop-Loss Premium within thirty (30) calendar days of receipt of a billing each Month.

The Stop-Loss Premium shall be subject to change by BCBSTX as follows:

a. At the end of the Policy Period shown in the most current Exhibit, provided that 120 days prior written notice is given by BCBSTX;

b. On the implementation date of any changes or benefit variances in the Employer's health benefit Plan, its administration, or the level of benefit valuation which would increase BCBSTX's risk;

c. On any date changes imposed by governmental entities increase expenses incurred by BCBSTX and/or HMO Blue Texas, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;

d. On any date that the number of Subscribers enrolled changes by an amount equal to 10% or more of total enrollment over a one-Month period or 25% or more of total enrollment over a three-Month period; or

e. On any date an affiliate, subsidiary, or other business entity is added or dropped from the Employer's health benefit Plan.

1.16 **Subscriber** means an individual employee, retired employee, or continued person, whose coverage has become effective under the portions of the Employer's health benefit Plan applicable to this Policy.

1.17 **Subscriber Unit** means the specific coverage issued for a Subscriber and his or her covered dependent(s), if any, under the Plan whose coverage is identified by a unique Subscriber identification (ID) number.

1.18 **Timely** means within thirty (30) calendar days following the occurrence of an event, the receipt of a billing statement, or the creation of any legal or contractual obligation, unless an alternative standard is specified and agreed to in writing by the Policyholder and BCBSTX. A charge, equal

to the amount specified in SECTION IX - GENERAL PROVISIONS, subsection 9.03, **Daily Charge**, may be assessed for late remittances.

1.19 **Valid Claim** means a claim incurred for supplies and/or services rendered to a Participant that is determined by the Claims Administrator or the Plan Administrator to be a covered benefit under the Plan during the term of this Agreement. For additional information regarding Valid Claim, which may also include Network access fees and Subscriber liability recalculations, refer to the Addendum A attached to and made a part of this Agreement.

SECTION II
SETTLEMENTS

2.01 **Remittance**. BCBSTX shall bill the Policyholder in advance for the Stop-Loss Premium amount due each Month and the Policyholder shall remit payment within thirty (30) calendar days of receipt of a billing. A charge, equal to the amount specified in SECTION IX - GENERAL PROVISIONS, subsection 9.03, **Daily Charge**, may be assessed for late remittances. A remittance will be considered received when actually delivered into the possession or control of BCBSTX at its office in Richardson, Texas.

2.02 **Individual (Specific) Stop-Loss Settlement**. Within 10 days after issuance of claim settlement report (as outlined in Addendum B), BCBSTX will settle with the Policyholder for any Individual (Specific) Stop-Loss Claims involved; provided, however, if the Plan, the Administrative Services Agreement between the Policyholder and BCBSTX, or this Policy are terminated on a date other than the end of a Policy Period, reports will be furnished and settlements will be made, as described herein, for only those full Months occurring within that portion of any Policy Period immediately preceding termination. Individual (Specific) Stop-Loss benefits shall not extend beyond the termination date of this Policy.

2.03 **Aggregate Stop-Loss Settlement or Accounting**:

a. BCBSTX will furnish the Policyholder an Aggregate Stop-Loss settlement report or accounting of claims within 90 days following the end of each Settlement Period during which this Policy was in effect.

If a settlement is required to be made under subsection 2.02, above, Aggregate Stop-Loss Claims under this subsection 2.03 shall not include any such Individual (Specific) Stop-Loss Claims.

b. If the Plan, the Administrative Services Agreement, or this Policy is terminated on a date other than the end of a Policy Period, no Aggregate Stop-Loss benefits will exist for the Final Policy Period or for the Run-Off Period. No settlement report or accounting will be provided and any Aggregate Stop-Loss Premium already paid will not be refunded. The Policyholder will be required to fund all claims

c. If the settlement report reflects that Paid Claims for the Settlement Period involved exceed the Point of Attachment, then Aggregate Stop-Loss benefits shall be payable to the Policyholder to the extent funded by the Policyholder. If the Point of Attachment exceeds the Paid Claims, then no Aggregate Stop-Loss benefit shall be payable to the Policyholder.

SECTION III
BANKING ARRANGEMENT

The banking arrangement and other financial responsibilities to apply under this Policy are described in Article VII and Addendum B of the PPO Administrative Agreement to which this Policy is attached and which is hereby incorporated and made a part hereto.

SECTION IV
ACCESS TO INFORMATION

4.01 **Access to Information**. BCBSTX and/or HMO Blue Texas and the Policyholder will allow each other reasonable access to Plan information. However, access to information that is a Record shall be under the terms of SECTION V - CONFIDENTIALITY of this Policy.

4.02 **Compliance with Laws and Regulations**. BCBSTX and Policyholder will comply with applicable state and federal laws and regulations regarding confidentiality or privacy of Records and other Plan information and will cooperate to ensure such compliance.

4.03 **Duration**. These rights of access and examination continue for three (3) years following the termination of this Policy.

SECTION V
CONFIDENTIALITY

5.01 BCBSTX and Policyholder agree that Records are valuable and confidential information.

5.02 BCBSTX agrees to protect as confidential and not disclose Records and the information they contain to any person or entity and to use these Records solely to perform services for the Policyholder under this Policy to the extent permitted by applicable laws.

5.03 Should the Policyholder request Records or the information contained in Records from BCBSTX, the Policyholder agrees to indemnify and hold harmless BCBSTX and its directors, officers, and employees against any and all loss, liability, damage, penalty, and expense resulting from or arising out of any allegation or claim based upon the disclosure by BCBSTX of any Record, or any information contained within a Record to Policyholder to the extent permitted by applicable laws.

Nothing contained herein shall be construed to require BCBSTX to provide copies of individual claim information for a specific Participant unless the Policyholder secures a valid written release from the Participant specifically related to the claim information.

5.04 BCBSTX and Policyholder agree that obligations in 5.02, above, do not apply to information that:

a. Is, or becomes, in the public domain,

b. Is independently developed by Policyholder,

c. Is previously known by Policyholder,

d. Is rightfully legally acquired from a third party not under an obligation of confidentiality,

e. Is disclosed pursuant to subpoena or similar process of a court or governmental agency,

f. Is disclosed pursuant to a written release executed by a Participant; or

g. Is disclosed pursuant to the *Texas Public Information Act* or similar applicable statute.

h. Is disclosed pursuant to a signed Business Associate Agreement between Policyholder and BCBSTX.

SECTION VI
RELATIONSHIP OF THE PARTIES

6.01 Neither party shall be construed, represented, or held out to be an agent, partner, associate, joint venturer, nor employee of the other. BCBSTX shall at all times have the status of an independent contractor.

6.02 It is understood and agreed that (i) the Plan Sponsor is the named Plan Administrator within the meaning of § 414(g) of the Internal Revenue Code of 1986, as amended, (ii) Plan Sponsor is the named Plan Administrator within the meaning of § 3(16)(A) of the Employee Retirement Income Security Act of 1974, as amended, (ERISA) and (iii) BCBSTX is not a fiduciary of the Plan or of the Employer or of the Plan Sponsor.

SECTION VII
TERM AND TERMINATION

7.01 This Policy shall continue in full force and effect from year to year unless terminated as provided herein.

7.02 This Policy may be terminated as follows:

a. By either party at the end of any Policy Period following ninety (90) days prior written notice to the other;

b. By Policyholder for cause, upon ten (10) days prior written notice (pursuant to SECTION IX -GENERAL PROVISIONS, **Notices and Satisfaction** subsection in the Policy) to BCBSTX, if BCBSTX fails to correct any deficiency in the performance of its duties or obligations within thirty (30) days after notice of such deficiency is given to BCBSTX by Policyholder in writing; or

c. By both parties on any date mutually agreed to in writing.

7.03 This Policy will terminate automatically:

a. Upon failure of the Policyholder to pay Stop-Loss Premiums in accordance with the provisions of SECTION I - DEFINITIONS, 1.15 of this Policy;

b. When the Plan terminates; or

c. When the PPO Administrative Agreement terminates.

SECTION VIII
INDEMNIFICATION AND HOLD HARMLESS

8.01 BCBSTX shall indemnify and hold the Policyholder harmless from and against all claims, demands, costs, damages, judgments, reasonable attorneys' fees, expenses and liabilities of any kind or nature (collectively, "Liabilities"), whether in equity or at law, arising from claims or demands made by Participants or other third parties against the Policyholder that occur as the result of the negligence or intentionally wrongful acts or omissions of BCBSTX or its employees, officers, directors, or agents arising out of or in any way connected with the duties and responsibilities of BCBSTX under this Policy.

8.02 In addition, BCBSTX shall indemnify and hold the Policyholder harmless, to the same extent as set forth in 8.01, above, in a lawsuit in which both BCBSTX and the Policyholder are parties, where the Policyholder is adjudicated by a trial court of competent jurisdiction not to be liable to any party. BCBSTX shall reimburse the Policyholder for its reasonable attorney's fees and out-of-pocket expenses in defending such lawsuit, even if BCBSTX is also adjudicated not to be liable to any party.

8.03 Notwithstanding the foregoing, BCBSTX's obligation to indemnify shall not extend to any of the following:

a. Liabilities arising from acts or omissions of the Policyholder, its officers, directors, employees, or agents, except those set out in 8.02, above; or

b. Any settlement to which BCBSTX has not given its prior consent in writing, provided that such consent shall not be unreasonably delayed, withheld, or qualified.

8.04 Nothing in this Policy shall be deemed to impose on BCBSTX, or the Policyholder any Liabilities arising from acts or omissions of health care providers who provide covered health care services and supplies to Participants.

8.05 The Policyholder agrees to immediately notify BCBSTX of any cause or action brought against the Policyholder or the Plan for which BCBSTX could ultimately be required to accept liability (subject to SECTION IX - GENERAL PROVISIONS, **Limitation of Liability** subsection in the Policy) for performance of its duties and responsibilities under this Policy. The Policyholder also agrees not to compromise or settle any such cause or action without the express written consent of BCBSTX, and that BCBSTX may, at its discretion, choose to defend any such cause or action.

SECTION IX
GENERAL PROVISIONS

9.01 **Assignment.** No part of this Policy, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. BCBSTX's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Policy.

9.02 **Captions.** Captions appearing in this Policy and its attachments are provided for convenience only and in no way define, limit, construe, or describe the scope of sections or paragraphs to which they are inserted.

9.03 **Daily Charge.** A daily charge shall be assessed for the late remittance of any amount(s) due and payable to BCBSTX by the Policyholder. This charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of .0329% per day (which equates to an amount of 12.0% per annum); or

b. The maximum rate permitted by state law.

9.04 **Enforcement.** Any delay or inconsistency in the enforcement of any part of this Policy shall not constitute a waiver of any rights with respect to the enforcement of this Policy at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Policy.

9.05 **Entirety.** This Policy and any attachments shall constitute the entire Policy between the parties for the purposes of this Policy and shall supersede any and all prior or contemporaneous Policies or understandings, either oral or in writing, between the parties respecting the subject matter herein.

9.06 **Forces Majeure and Majesture.** Neither party shall be liable for failure to Timely perform its obligations under this Policy if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, or restraints of government.

9.07 **Gender and Mode.** The use herein of a personal pronoun in the masculine or feminine gender or in the singular or plural mode, shall be deemed to include the opposite gender or mode unless the context clearly indicates the contrary.

9.08 **Governing Law.** This Policy shall be governed by, and shall be construed in accordance with, the laws of the State of Texas without regard to any state choice-of-law statutes, and any applicable federal law. All obligations created hereunder are performable in the state of Texas and all disputes arising out of this Policy will be resolved in the state of Texas.

9.09 **Legal Construction.** Should any provision(s) contained in this Policy be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Policy shall be construed in their entirety as if separate and apart from the invalid, illegal, or unenforceable provision(s) unless such construction were to materially change the terms and conditions of the Policy. As this Policy was negotiated between parties of equal bargaining positions and was not drafted

solely by either party, there shall be no presumption regarding construction against the party drafting this Policy.

9.10 **Limitation of Liability**. Liability for any errors or omissions by BCBSTX (or its officers, directors, employees, agents, or independent contractors) in the administration of this Policy, or in the performance of any duty of responsibility contemplated by this Policy, shall be limited to the maximum benefits which should have been paid under the Policy had the errors or omissions not occurred (including BCBSTX's share of any arbitration expenses incurred under the Policy), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence, or intentional breach of a duty under this Policy by BCBSTX to the extent permitted by applicable law.

9.11 **Modification**. Except for the Exhibit to this Policy, which may be changed at any time in accordance with the provisions described in SECTION I – DEFINITIONS, 1.15 of this Policy by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Policy shall be valid unless agreed to by an officer of BCBSTX and the Policyholder's governing body.

9.12 **Notices.** All notices given under this Policy must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first-class postage prepaid and addressed to the parties at their respective addresses shown below, or when transmitted by facsimile.

For the Employer/Policyholder, the name and address of the financial contact person shall be maintained on file in accordance with procedures established by the Comptroller Division of the Accounting Services Department of BCBSTX.

For BCBSTX, the address and facsimile are as shown below:

Comptroller-Accounting Services
Blue Cross and Blue Shield of Texas
901 South Central Expressway
Richardson, Texas 75080
FAX: (972) 766-6210

9.13 **Notice and Satisfaction**. The Policyholder agrees to give BCBSTX specific notice (pursuant to SECTION IX - GENERAL PROVISIONS, **Notices** subsection) of any complaint or concern the Policyholder may have about the performance of duties under this Policy and to allow BCBSTX thirty (30) days in which to make necessary adjustments or corrections to satisfy any such complaint or concern prior to the Policyholder taking any further action with regard to the complaint or concern.

9.14 **Required Notice**. The Employer, on behalf of itself and its Participants, understands that this Policy constitutes a contract solely between the Employer and Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an independent licensee of the Blue Cross and Blue Shield Association (the Association). The license from the Association permits BCBSTX to use the Blue Cross and Blue Shield Service Marks in the State of Texas. BCBSTX is not contracting as the agent of the Association. Said Employer also understands that it has not entered into this Policy based upon representations by any person other than BCBSTX. No person, entity, or organization other than

Legal Reserve Company, and an independent licensee of the Blue Cross and Blue Shield Association (the Association). The license from the Association permits BCBSTX to use the Blue Cross and Blue Shield Service Marks in the State of Texas. BCBSTX is not contracting as the agent of the Association. Said Employer also understands that it has not entered into this Policy based upon representations by any person other than BCBSTX. No person, entity, or organization other than BCBSTX shall be held accountable or liable to the Employer for any of BCBSTX's obligations to the Employer created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSTX other than those obligations created under other provisions of this Policy.

9.15 **Taxes.** Any premium amounts due under this Policy will automatically be increased by the amount of any taxes imposed, increased, or adjudged due by any lawful authority on or after the Effective Date of this Policy, which directly pertain to this Policy and which BCBSTX is required to pay or remit, whether relating to fees, services, benefits, payments, or any other aspect of this Policy or the Plan.

SECTION X
ATTACHMENTS TO THIS POLICY

10.01 The following Exhibit(s) are attached to and are made a part of this Policy:

☒ **Exhibit** of Schedule of Specifications to the Stop-Loss Policy

10.02 The following Addenda to the PPO Administrative Agreement are attached to and made part of this policy:

☒ Addendum B – Transfer Payment and Other Financial Responsibilities
☒ Addendum A – Blue Cross and Blue Shield Association Required Notices

City of Houston

By: _____
Name/Title

Date: _____

Blue Cross and Blue Shield of Texas

By _____
Martin G. Foster, President

Date: _____

Exhibit H-1
Schedule of Specifications

to the

STOP-LOSS POLICY
(the Policy)

between

Blue Cross and Blue Shield of Texas *
(BCBSTX)

and

City of Houston
(Policyholder)

Group Number: 69184, 70883, 70885

These specifications shall apply for the period of time indicated herein and shall continue in force and effect until the end of the Policy Period, the Policy is terminated, or this Exhibit is superseded in whole or in part by a later executed Exhibit.

Item One
Policy Period

These specifications are for the Policy Period commencing on May 1, 2006 and ending on April 30, 2007.

The amount of increase for the Premium Rates and Claim Liability Factors for the following periods are limited in accordance with the provisions stated in Exhibit G:

The period commencing on May 1, 2007 and ending on April 30, 2008,
The period commencing on May 1, 2008 and ending on April 30, 2009,
The period commencing on May 1, 2009 and ending on April 30, 2010,
The period commencing on May 1, 2010 and ending on April 30, 2011

Item Two
Stop-Loss Premium

The Stop-Loss Premium is the sum of the Individual Stop-Loss Premium and Aggregate Stop-Loss Premium amounts calculated as follows:

A. Individual Stop-Loss Premium shall be calculated Monthly and shall be equal to the sum of the amounts obtained by multiplying the number of Subscriber Units covered, excluding Plan A participants, for a particular Month by:

$6.31	for each Employee Only Subscriber Unit
$15.21	for each Employee + 1 Subscriber Unit
$20.01	for each Employee + 2 or more Subscriber Unit

B. Aggregate Stop-Loss Premium shall be calculated Monthly and shall be equal to the sum of the amounts obtained by multiplying the number of Subscriber Units covered, excluding Plan A participants, for a particular Month by:

$13.95	for each Employee Only Subscriber Unit
$33.63	for each Employee + 1 Subscriber Unit
$44.24	for each Employee + 2 or more Subscriber Unit

Item Three
Claim Liability Factors

A. Claim Liability for the Policy Period shall be the sum of the Monthly amounts obtained by multiplying the number of Subscriber Units covered, excluding Plan A participants, for each Month by the following factors:

$489.81	for each Employee Only Subscriber Unit
$1,180.92	for each Employee + 1Subscriber Unit
$1,553.13	for each Employee + 2 or more Subscriber Unit

Item Four
Stop-Loss Insurance

Stop-Loss claims shall include those claims incurred on or after May 1, 2006 but on or before April 30, 2007 and paid between May 1, 2006 and July 31, 2007 under the terms of the Plan Sponsor's health benefit plan in effect.

The **Settlement Period** for Stop-Loss Insurance shall begin on May 1 of each **Policy Period** and end on the last day of the 15th Month thereafter.

A. Individual (Specific) Stop-Loss Insurance

1. The portion(s) of the Master Benefit Plan Document that describes the benefits applicable to Individual (Specific) Stop-Loss Insurance:

   - PPO Managed Health Care coverage
   - Traditional (Out-of-Area) Indemnity coverage
   - Prescription Drug Program coverage

2. For N/A who is identified by the subscriber identification number N/A, the amount of Paid Claims during the current Policy Period in excess of the Point of Attachment of $N/A but not to exceed a maximum Point of Attachment of $ N/A. Such amounts shall apply for the Policy Period.

3. For each other Participant, the amount of Paid Claims during the current Policy Period in excess of the Point of Attachment of $300,000 per Participant but not to exceed a maximum Point of Attachment of $1,200,000 per Participant. Such amounts shall apply for the Policy Period.

B. **Aggregate Stop-Loss Insurance**

1. The portion(s) of the Master Benefit Plan Document that describes the benefits applicable to Aggregate Stop-Loss Insurance:

   - PPO Managed Health Care coverage
   - Traditional (Out-of-Area) Indemnity coverage
   - Prescription Drug Program coverage

2. The Point of Attachment shall equal the sum of the Claim Liability amounts calculated Monthly as described in Item Three-A, above, for the indicated Policy Period. In the event of termination at the end of a Policy Period, the Final Settlement Point of Attachment shall equal the sum of the Claim Liability amount for the Final Policy Period calculated as described in Item Three-A but in no event shall the Point of Attachment be less than $11,616,340.

3. Aggregate Stop-Loss benefit payments shall not exceed a maximum of $2,000,000 for the indicated Policy Period.

City of Houston

By _____
Name/Title

Date _____

Blue Cross and Blue Shield of Texas

By _____
Martin G. Foster, President

Date _____

B. **Aggregate Stop-Loss Insurance**

1. The portion(s) of the Master Benefit Plan Document that describes the benefits applicable to Aggregate Stop-Loss Insurance:

   - PPO Managed Health Care coverage
   - Traditional (Out-of-Area) Indemnity coverage
   - Prescription Drug Program coverage

2. The Point of Attachment shall equal the sum of the Claim Liability amounts calculated Monthly as described in Item Three-A, above, for the indicated Policy Period. In the event of termination at the end of a Policy Period, the Final Settlement Point of Attachment shall equal the sum of the Claim Liability amount for the Final Policy Period calculated as described in Item Three-A but in no event shall the Point of Attachment be less than $11,616,340.

3. Aggregate Stop-Loss benefit payments shall not exceed a maximum of $2,000,000 for the indicated Policy Period.

City of Houston

By _____
Name/Title

Date _____

Blue Cross and Blue Shield of Texas

By _____
Martin G. Foster, President

Date _____

EXHIBIT "I"

EQUAL EMPLOYMENT OPPORTUNITY

1. The contractor*, subcontractor, vendor, supplier, or lessee will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, or age. The contractor, subcontractor, vendor, supplier, or lessee will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, sex, national origin, or age. Such action will include, but not be limited to, the following: employment; upgrading; demotion or transfer; recruitment advertising; layoff or termination; rates of pay or other forms of compensation and selection for training, including apprenticeship. The contractor, subcontractor, vendor, supplier or lessee agrees to post in conspicuous places available to employees, and applicants for employment, notices to be provided by the City setting forth the provisions of this Equal Employment Opportunity Clause.

2. The contractor, subcontractor, vendor, supplier, or lessee states that all qualified applicants will receive consideration for employment without regard to race, religion, color, sex, national origin or age.

3. The contractor, subcontractor, vendor, supplier, or lessee will send to each labor union or representatives of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the agency contracting officer advising the said labor union or worker's representative of the contractor's and subcontractor's commitments under Section 202 of Executive Order No. 11246, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. The contractor, subcontractor, vendor, supplier, or lessee will comply with all provisions of Executive Order No. 11246 and the rules, regulations, and relevant orders of the Secretary of Labor or other Federal Agency responsible for enforcement of the equal employment opportunity and affirmative action provisions applicable and will likewise furnish all information and reports required by the Mayor and/or Contractor Compliance Officer(s) for purposes of investigation to ascertain and effect compliance with this program.

5. The contractor, subcontractor, vendor, supplier, or lessee will furnish all information and reports required by Executive Order No. 11246, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to all books, records, and accounts by the appropriate City and Federal Officials for purposes of investigations to ascertain compliance with such rules, regulations, and orders. Compliance reports filed at such times as directed shall contain information as to the employment practice policies, program, and work force statistics of the contractor, subcontractor, vendor, supplier, or lessee.

6. In the event of the contractor's, subcontractor's, vendor's, supplier's, or lessee's non-compliance with the non-discrimination clause of this contract or with any of such rules, regulations, or orders, this contract may be canceled, terminated, or suspended in whole or in part, and the contractor, subcontractor, vendor, supplier, or lessee may be declared ineligible for further City contracts in accordance with procedures provided in Executive Order No. 11246, and such other sanctions may be imposed and remedies invoked as provided in the said Executive Order, or by rule, regulation, or order of the Secretary of Labor, or as may otherwise be provided by law.

7. The contractor shall include the provisions of paragraphs 1-8 of this Equal Employment Opportunity Clause in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontractor or purchase order as the contracting agency may direct as a means of enforcing such provisions including sanctions for noncompliance; provided, however, that in the event the contractor becomes involved in, or is threatened with litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the contractor may request the United States to enter into such litigation to protect the interests of the United States.

8. The contractor shall file and shall cause his or her subcontractors, if any, to file compliance reports with the City in the form and to the extent as may be prescribed by the Mayor. Compliance reports filed at such times as directed shall contain information as to the practices, policies, programs, and employment policies and employment statistics of the contractor and each subcontractor.

* For purposes of this Exhibit "A", Contractor shall be used instead of Administrator

EXHIBIT J

MINORITY AND WOMEN BUSINESS ENTERPRISE REQUIREMENTS

It is the City's policy to encourage participation of certified local minority and women business enterprises (MWBEs) in City contracts. Vendors will be required to make a good-faith effort to meet annual MWBE goals.

- PPO goal: Administrators shall make good faith efforts to award subcontracts or supply agreements in at least an amount equal to fifteen percent (15%) of the administrative services fee paid to the Administrator hereunder.

Items that are eligible for satisfaction of the goal include medical services, printing costs, laboratories, translation services, and any others listed in the current City of Houston MWBE directory. However, good faith efforts must include solicitations to firms that provide medical and directly related services.

The City's policy does not require contractors or administrators to in fact meet or exceed goals, but it does require them to objectively demonstrate that it has made good faith efforts to do so. To this end, they shall maintain records showing:

1. subcontracts and supply agreements with Minority Business Enterprises,
2. subcontracts and supply agreements with Women's Business Enterprises, and
3. specific efforts to identify and award subcontracts and supply agreements to MWBEs. Administrator shall submit periodic reports of its efforts under this Section to the Affirmative Action Director in the form and at the times the Director prescribes.

Administrators shall require written subcontracts with all MWBE subcontractors and suppliers and shall submit all disputes with MWBE subcontractors to binding arbitration if directed to do so by the Affirmative Action Director. All agreements must contain the terms set out in Section J-1.

NETWORK GOAL

The city has a strong commitment to offering employees and retirees a diverse provider network. The City will monitor the provider network to ensure that it represents a cross section of the community and that at least thirty percent (30%) of the physicians are minority and/or female.

EXHIBIT "J-1"

MWBE SUBCONTRACT TERMS

Administrator shall ensure that all subcontracts with MWBE subcontractors and suppliers are clearly labeled "**THIS AGREEMENT IS SUBJECT TO BINDING ARBITRATION ACCORDING TO THE TEXAS GENERAL ARBITRATION ACT**" and contain the following terms:

1. _____ (MWBE subcontractor) shall not delegate or subcontract more than 50% of the work under this subcontract to any other subcontractor or supplier without the express written consent of the City of Houston's Affirmative Action Director ("the Director").

2. _____ (MWBE subcontractor) shall permit representatives of the City of Houston, at all reasonable times, to perform (1) audits of subcontractor's books and records, and (2) inspections of all places where work is to be undertaken in connection with this subcontract. Subcontractor shall keep its books and records available for inspection for at least 4 years after the end of its performance under this subcontract. Nothing in this provision shall change the time for bringing a cause of action.

3. Within 5 business days of execution of this subcontract, Administrator (prime contractor) and Subcontractor shall designate in writing to the Director an agent for receiving any notice required or permitted to be given under Chapter 15 of the Houston City Code of Ordinances, along with the street and mailing address and phone number of the agent.

4. Any controversy between the parties involving the construction or application of any of the terms, covenants, or conditions of this subcontract must, upon the written request of one party served upon the other or upon notice by the Director served on both parties, be submitted to binding arbitration, under the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code Ann., Ch. 171 -- "the Act"). Arbitration must be conducted according to the following procedures:

a. Upon the decision of the Director or upon written notice to the Director from either party that a dispute has arisen, the Director shall notify all parties that they must resolve the dispute within 30 days or the matter may be referred to arbitration.

b. If the dispute is not resolved within the time specified, any party or the Director may submit the matter to arbitration conducted by the American Arbitration Association under the rules of the American Arbitration Association, except as otherwise required by the City's contract with the American Arbitration Association on file in the City's Affirmative Action Division Office.

c. Each party shall pay all fees required by the American Arbitration Association and sign a form releasing the American Arbitration Association and its arbitrators from liability for decisions reached in the arbitration.

d. If the American Arbitration Association no longer administers Affirmative Action arbitration for the City, the Director shall prescribe alternate procedures to provide arbitration by neutrals in accordance with the requirements of Chapter 15 of the Houston City Code of Ordinances.

EXHIBIT "K" PPO
LIMIT OF APPROPRIATION

(1) The City's duty to pay money to Administrator under this Agreement is limited in its entirety by the provisions of this Section.

(2) In order to comply with Article II, Sections 19 and 19a of the City's Charter and Article XI, Section 5 of the Texas Constitution, the City has appropriated and allocated the sum of $199,900 to pay money due under this Agreement (the "Original Allocation"). The executive and legislative officers of the City, in their discretion, may allocate supplemental funds for this Agreement, but they are not obligated to do so. Therefore, the parties have agreed to the following procedures and remedies:

(3) The City Council hereby approves a supplemental allocation to be effective on July 1, of each contract year from funds appropriated in connection with the budget for the City's fiscal year beginning July 1 and ending June 30, in the amount of $1,100,000. Thereafter, the amount of $1,100,000 shall increase by the annual percentage increase in premiums. Each City fiscal year, the City Council authorizes the Director of Human Resources to make one or more additional supplemental allocations of up to $110,000 for this Agreement, without returning to City Council. The City shall send BCBSTX a notice signed by the Director of Human Resources and the Controller in substantially the following form:

"NOTICE OF SUPPLEMENTAL ALLOCATION OF FUNDS"

TO: [Name of Administrator]

FROM: City of Houston, Texas (the "City")

DATE: [Date of notice]

SUBJECT: Supplemental allocation of funds for the purpose of the "[title of this Agreement]" between the City and (name of Administrator) countersigned by the City Controller on (Date of Countersignature) (the "Agreement").

I, (name of City Controller), City Controller of the City of Houston, certify that the supplemental sum of $_____, upon the request of the below-signed Director, has been allocated for the purposes of the Agreement out of funds appropriated for this purpose by the City Council of the City of Houston. This supplemental allocation has been charged to such appropriation.

The aggregate of all sums allocated for the purpose of such Agreement, including the Original Allocation, and all supplemental allocations (including this one), as of the date of this notice, is $_____.

SIGNED:

(Signature of the City Controller)
City Controller of the City

REQUESTED:

(Signature of the Director)
Director

(4) The Original Allocation plus all supplemental allocations are the Allocated Funds. The City shall never be obligated to pay any money under this Agreement in excess of the Allocated Funds. Administrator must assure itself that sufficient allocations have been made to pay for services it provides. If Allocated Funds are

exhausted, Administrator's only remedy is suspension or termination of its performance under this Agreement, and it has no other remedy in law or in equity against the City and no right to damages of any kind.

EXHIBIT "L"

Drug Abuse Detection and Deterrence

(1) It is the policy of the City to achieve a drug-free workforce and workplace. The manufacture, distribution, dispensation, possession, sale, or use of illegal drugs or alcohol by contractors while on City Premises is prohibited. Administrator shall comply with all the requirements and procedures set forth in the Mayor's Drug Abuse Detection and Deterrence Procedures for Contractors, Executive Order No. 1-31 ("Executive Order"), which is incorporated into this Agreement and is on file in the City Secretary's Office.

(2) Before the City signs this Agreement, Administrator shall file with the Contract Compliance Officer for Drug Testing ("CCODT"):

(a) a copy of its drug-free workplace policy,
(b) the Drug Policy Compliance Agreement substantially in the form set forth in Exhibit "L-1," together with a written designation of all safety impact positions and,
(c) if applicable (e.g. no safety impact positions), the Certification of No Safety Impact Positions, substantially in the form set forth in Exhibit "L-2."

If Administrator files a written designation of safety impact positions with its Drug Policy Compliance Agreement, it also shall file every 6 months during the performance of this Agreement or on completion of this Agreement if performance is less than 6 months, a Drug Policy Compliance Declaration in a form substantially similar to Exhibit "L-3." Administrator shall submit the Drug Policy Compliance Declaration to the CCODT within 30 days of the expiration of each 6-month period of performance and within 30 days of completion of this Agreement. The first 6-month period begins to run on the date the City issues its Notice to Proceed or if no Notice to Proceed is issued, on the first day Administrator begins work under this Agreement.

(3) Administrator also shall file updated designations of safety impact positions with the CCODT if additional safety impact positions are added to Administrator's employee work force.

(4) Administrator shall require that its subcontractors comply with the Executive Order, and Administrator shall secure and maintain the required documents for City inspection.

EXHIBIT "L-1"

DRUG POLICY COMPLIANCE AGREEMENT

I, _____ as an owner or officer of
(Name) (Print/Type) (Title)

(Administrator)

(Name of Company)

have authority to bind Administrator with respect to its bid, offer or performance of any and all contracts it may enter into with the City of Houston; and that by making this Agreement, I affirm that the Administrator is aware of and by the time the contract is awarded will be bound by and agree to designate appropriate safety impact positions for company employee positions, and to comply with the following requirements before the City issues a notice to proceed:

1. Develop and implement a written Drug Free Workplace Policy and related drug testing procedures for the Administrator that meet the criteria and requirements established by the Mayor's Amended Policy on Drug Detection and Deterrence (Mayor's Drug Policy) and the Mayor's Drug Detection and Deterrence Procedures for Administrators (Executive Order No. 1-31).

2. Obtain a facility to collect urine samples consistent with Health and Human Services (HHS) guidelines and a HHS certified drug testing laboratory to perform the drug tests.

3. Monitor and keep records of drug tests given and the results; and upon request from the City of Houston, provide confirmation of such testing and results.

4. Submit semi-annual Drug Policy Compliance Declarations.

I affirm on behalf of the Administrator that full compliance with the Mayor's Drug Policy and Executive Order No. 1-31 is a material condition of the contract with the City of Houston.

I further acknowledge that falsification, failure to comply with or failure to timely submit declarations and/or documentation in compliance with the Mayor's Drug Policy and/or Executive Order No. 1-31 will be considered a breach of the contract with the City and may result in non-award or termination of the contract by the City of Houston.

_____
Date

Administrator Name

_____
Signature

_____
Title

EXHIBIT "L-2"

Administrator'S CERTIFICATION
OF NO SAFETY IMPACT POSITIONS
IN PERFORMANCE OF A CITY CONTRACT

I, _____, _____,
(Name) (Title)

as an owner or officer of _____ (Administrator)
(Name of Company)

have authority to bind the Administrator with respect to its bid, and hereby certify that Administrator has no employee safety impact positions, as defined in §5.17 of Executive Order No. 1-31, that will be involved

in performing _____.
(Project)

Administrator agrees and covenants that it shall immediately notify the City of Houston Director of Personnel if any safety impact positions are established to provide services in performing this City Contract.

_____
(Date)

(Typed or Printed Name)

(Signature)

(Title)

EXHIBIT "L-3"

DRUG POLICY COMPLIANCE DECLARATION

I, _____ as an owner or officer of
(Name) (Print/Type) (Title)

_____ (Administrator)
(Name of Company)

have personal knowledge and full authority to make the following declarations:

This reporting period covers the preceding 6 months from _____ to _____, 20__.

_____ Initials — A written Drug Free Workplace Policy has been implemented and employees notified. The policy meets the criteria established by the Mayor's Amended Policy on Drug Detection and Deterrence (Mayor's Policy).

_____ Initials — Written drug testing procedures have been implemented in conformity with the Mayor's Drug Detection and Deterrence Procedures for Contractors, Executive Order No. 1-31. Employees have been notified of such procedures.

_____ Initials — Collection/testing has been conducted in compliance with federal Health and Human Services (HHS) guidelines.

_____ Initials — Appropriate safety impact positions have been designated for employee positions performing on the City of Houston contract. The number of employees in safety impact positions during this reporting period is _____.

_____ Initials — From _____ (Start date) to _____ (End date) the following test has occurred

	Random	Reasonable Suspicion	Post Accident	Total
Number Employees Tested				
Number Employees Positive				
Percent Employees Positive				

_____ Initials — Any employee who tested positive was immediately removed from the City worksite consistent with the Mayor's Policy and Executive Order No. 1-31.

_____ Initials — I affirm that falsification or failure to submit this declaration timely in accordance with established guidelines will be considered a breach of contract.

I declare under penalty of perjury that the affirmations made herein and all information contained in this declaration are within my personal knowledge and are true and correct.

_____
(Date)

(Typed or Printed Name)

(Signature)

(Title)

Exhibit M

City of Houston
Self-Funded PPO Claims Projection
5/1/200X

Date of Service	to	(12 months)
Date of Payment	to	(15 months)

1 12/15 Claim
2 Remove Large Claims
3 Number of Large Claims
4 IBNR Adjustment
5 Adjusted 12/15 claims
6 Contract months
7 Average Claim Value(ACV) Per Employee Per Month
8 Overall Trend Factor
9 Trended ACV Per Employee Per Month
10 Benefit Adjustment
11 Dependent Ratio Adjustment
12 Provider Contract Adjustment
13 Adjusted ACV Per Employee Per Month
14 Large Claim Adjustment Per Employee Per Month
15 Expected 12/15 Claims
16 Current Expected 12/15 Claims
17 Needed Increase

Notes:
1 12/15 – Medical and Presription Drug Claims for the time period shown above.
2 Remove Large Claims – The total amount of all claims over the stop loss deductible level for the time period shown above
3 Number of Large Claims – The number of large claims that have been removed in line 2
4 IBNR Adjustment - Adjustment for Incurred But Not Report Claims
5 Adjusted 12/15 claims Line 1 minus line 2 plus line 4
6 Contracts months – The sum of all contracts (employees) enrolled for each month of the "Date of Service " shown above
7 Average Claim Value(ACV) Per Employee Per Month - Line 5 divided by line 6
8 Overall Trend Factor - The annual trend factor adjusted for the number of months from the midpoint of the "Date of Service" shown above to the mid point of the projected contract period.
9 Trended ACV Per Employee Per Month – (Line 8 plus 1) times line 7
10 Benefit Adjustment - Adjustment for either retrospective or prospective Benefit Changes
11 Dependent Ratio Adjustment - The change between the dependent ratio for the "Date of Service" shown above versus the dependent ratio for the most recent month available
12 Provider Contract –Claim adjustments to reflect changes in contracted provider reimbursements not included in Line1
13 Adjusted ACV Per Employee Per Month – (Line 9) times (line 10 plus 1)times (line 11 plus 1) times (line 12 plus 1).
14 Large Claim Adjustment Per Employee Per Month - (Line 3 times the specific stop loss deductible level) divided by line 6.
15 Expected 12/15 Claims – Line 13 plus line 14.
16 Current Expected 12/15 Claims – The expected 12/15 claims for the current contract period.
17 Needed Increase- (Line 15 divided by line 16) minus 1.

BlueCross BlueShield of Texas

EXHIBIT N

RETIREE DRUG SUBSIDY (RDS) DATA EXCHANGE AGREEMENT

I. PURPOSE

This agreement (the "Agreement") is made as of May 1, 2006 (the "Effective Date") by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and The City of Houston, the Employer and/or Sponsor of a retiree drug benefit plan ("Employer"), for the purpose of delineating the terms and conditions for the information and data exchanges and other services that HCSC will provide related to Employer's participation in the retiree drug subsidy ("RDS") program administered by the Centers for Medicare & Medicaid Services ("CMS").

II. DEFINITIONS

A. The terms "Allowable Retiree Costs," "Benefit Option," "Gross Covered Retiree Plan-related Prescription Drug Costs," "Gross Retiree Costs," "Group Health Plan", "Part D Drug", "Qualified Retiree Prescription Drug Plan" and "Qualifying Covered Retiree" shall have the same meaning as in 42 C.F.R. §423.882.

B. The term "Data Match" means the match performed by CMS to determine which retirees submitted on Employer's Initial List of Qualifying Covered Retirees or Updated Lists of Qualifying Covered Retirees are Part D Eligible Individuals who are not enrolled in a Part D plan.

C. The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated pursuant to that act.

D. The term "Initial List of Qualifying Covered Retirees" means a list of all individuals Employer believes (using information reasonably available to Employer when it submits an RDS application) are Qualifying Covered Retirees enrolled in each prescription drug plan (including spouses and dependents, if Medicare-eligible) and that is submitted to CMS with an RDS application required by 42 C.F.R. §423.884(c)(2)(v).

E. The term "Part D Eligible Individual" means an individual enrolled in Employer's Group Health Plan who is entitled to Medicare benefits under Part A or enrolled in Medicare Part B and lives in the service area of a Part D plan as defined under 42 C.F.R. §423.4.

F. The term "Reported RDS Drug" shall have the same meaning as "Part D Drug", above, but the meaning shall exclude certain prescription drugs to the extent the drugs are or might be payable under Medicare Part B.

G. The term "RDS Requirements" means the requirements of 42 C.F.R. Part 423, Subpart R (42 C.F.R. §423.880 et seq.), together with any other regulations, subregulatory guidance and policies promulgated from time to time to implement Section 1860D-22 of the Social Security Act.

H. The term "Rebates" shall mean any manufacturer or pharmacy discounts, chargebacks, rebates, and similar price concessions received by HCSC after the point of sale that are attributable to covered Part D drugs provided to **Employer's** Qualifying Covered Retirees.

I. The term "Updated Lists of Qualifying Covered Retirees" means the updates to the Initial List of Qualifying Covered Retirees required by 42 C.F.R. §423.884(c)(6).

III. TERM AND TERMINATION

A. Term. The term of this Agreement will commence on the Effective Date and will continue until terminated on April 30, 2009. This Agreement shall be included in its entirety in any subsequent contracts between the City of Houston and HCSC commencing after that date.

B. Termination of Agreement. The Agreement may be terminated under any of the following circumstances:

1. Termination with Notice. Either party may terminate this Agreement in its entirety at any time upon ninety (90) days' prior written notice to the other party.

2. Termination for Material Breach. In the event that either party fails to cure a material breach of this Agreement within thirty (30) days of receipt of written notice to cure from the other (which notice will state the material breach with specificity and attach any then available documentation of the material breach), the non-defaulting party may terminate this Agreement immediately upon conclusion of such thirty (30) day period, or if the breach is one that cannot reasonably be corrected within thirty (30) days, and the non-defaulting party determines that the defaulting party is making substantial and diligent progress toward correction during such thirty (30) day period, this Agreement will remain in full force and effect.

3. Termination Based on Failure to Reach Agreement Following Regulatory Change. Either party may terminate this Agreement effective sixty (60) days after either party provides written notice that it is unable to agree on any amendment required under Section X.C.

C. Transition Requirements. If this Agreement is terminated by HCSC under Section III.B.1. or by either party under Section III.B.3., then the parties agree to take the following specific actions to minimize disruption:

1. Transition Plan. The parties will develop and implement a detailed plan for transitioning the services and both parties will cooperate fully to arrange for the transfer of services to Employer's designee.

2. Transition Period. HCSC will continue to provide services in accordance with this Agreement for a reasonable transition period. Unless the parties mutually agree otherwise, the transition period will not exceed twelve (12) months from the date of notice of termination. Except as otherwise provided in this Agreement, the terms and conditions of this Agreement will apply during the transition period.

IV. SCOPE OF SERVICES AND RESPONSIBILITIES OF THE PARTIES

A. RDS Application.

1. Responsibility for Preparing and Submitting RDS Application. Employer will be responsible for preparing and submitting the RDS application. HCSC agrees to provide to Employer any data in its possession that Employer requires in order to complete its application.

2. Attestation of Actuarial Equivalence. Employer shall be responsible for obtaining or preparing the attestation of actuarial equivalence for its Qualified Retiree Prescription Drug Plan. HCSC agrees to provide, to the best of its ability, any data in HCSC's possession that Employer requests for the actuarial analysis.

3. Certificates of Creditable Prescription Drug Coverage.

   a. Determination of Creditable Prescription Drug Coverage. Employer shall be responsible for determining whether the prescription drug coverage provided under Employer's Group Health Plan(s) is creditable prescription drug coverage within the meaning of 42 C.F.R. §423.56. HCSC agrees to provide all information requested by Employer (or a third party designated by Employer) within fifteen (15) business days of receiving such request, or within an alternative timeframe mutually agreed upon by the parties.

   b. Preparation and Distribution of Certificates of Creditable Prescription Drug Coverage. Employer shall be responsible for preparing and distributing certificates of creditable prescription drug coverage and, if applicable, non-creditable prescription drug coverage. The certificates shall comply with the creditable coverage guidance issued by CMS and shall be distributed to all Part D Eligible Individuals enrolled in Group Health Plans(s) designated by Employer.

4. List of Qualifying Covered Retirees.

   a. Responsibility and Standard for Determining Qualifying Covered Retirees. Employer shall be solely responsible for determining whether an enrollee in Employer's qualified prescription drug plan is a Qualifying Covered Retiree using information reasonably available to Employer in accordance

with 42 C.F.R. §423.884(c)(2). HCSC shall have no responsibility to determine or confirm whether a particular enrollee is a Qualifying Covered Retiree.

b. Responsibility for Preparing Lists of Qualifying Covered Retirees. Employer shall be solely responsible for preparing and submitting to CMS the Initial List of Qualifying Covered Retirees and Updated Lists of Qualifying Covered Retirees. HCSC will continue to provide employer with a monthly report listing all subscribers and dependent members by name and social security number for whom HCSC is reducing HMO or PPO benefits paid and/or capitation to physicians, representing a Medicare carve-out.

c. CMS Data Match. Employer shall receive Data Match information from CMS and shall be solely responsible for cross-checking the CMS Data Match information against Employer's Initial List of Qualifying Covered Retirees and Updated Lists of Qualifying Covered Retirees, and for deleting from such list any individual who is not a Qualifying Covered Retiree.

B. Data Required for RDS Payments.

1. Responsibility for Compiling and Submitting Data. Employer, or a third party designated by Employer, shall be responsible for submitting data to CMS. Employer will provide HCSC with Employer's appropriate list of Qualifying Covered Retirees determined consistent with RDS Requirements at least fifteen (15) days in advance of the date it requires data from HCSC. HCSC will compile and submit to Employer the following data for retirees on the appropriate list provided by Employer on a monthly basis:

   a. Gross Covered Retiree Plan-related Prescription Drug Costs;

   b. For interim payments, an estimate of the expected Rebates known to HCSC; and

   c. For one-time annual payments and reconciliation purposes, the actual Rebate data known to HCSC for the plan year of Employer's Qualified Retiree Prescription Drug Plan.

   HCSC shall submit all data to Employer or Employer's designee, in the aggregate for all Qualifying Covered Retirees and for each individual Qualifying Covered Retiree. Employer confirms that it has or will review the list of Reported RDS Drugs that HCSC will provide under this Agreement. Employer specifically understands and agrees that, pursuant to the terms of this Agreement, such information will not include certain prescription drugs to the extent the drugs are or might be payable under Medicare Part B and that this exclusion may result in a lower subsidy amount and Until clarified by CMS, the term "Rebates" shall mean any manufacturer or pharmacy discounts, chargebacks, rebates, and similar price concessions received by HCSC after the point of sale that are attributable to covered Part D drugs provided to Employer's Qualifying Covered Retirees.

2. Receipt of RDS Payments. Employer shall receive all RDS payments from the United States government directly, and HCSC shall have no reponsibility for claiming, receiving or handling such payments.

C. Corrections and Modifications. Should HCSC learn that any data provided by either party to this Agreement or by any third party is or was inaccurate, that Employer is or has received RDS overpayments, or that Employer's RDS application, Part D Drug cost data, or any submission to CMS fail to comply with RDS Requirements, it shall notify Employer, and Employer shall have the sole responsibility for making necessary corrections and communications to CMS.

D. Employer's Third Party Consultant and/or Vendor. In the event Employer directs HCSC to provide data directly to its third party consultant and/or vendor, the Employer acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

1. The personal and confidential nature of the requested documents, records and other information (hereinafter referred to as "Confidential Information").
2. Release of the Confidential Information may also reveal HCSC's confidential, business proprietary, and trade secret information (hereinafter referred to as "Proprietary Information").
3. To maintain the confidentiality of the Confidential Information and any Proprietary Information disclosed with Confidential Information (collectively referred to herein as "Information").
4. Consultant and/or vendor shall:
    a. Use the Information only for the purpose of complying with the terms and conditions of the contract between Employer and consultant and/or vendor.
    b. Maintain the Information at a specific location under the control of consultant and/or vendor and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of it to third parties, including those of its employees not directly involved in the performance of duties under the contract with Employer.
    c. Advise its employees who receive the Information of the existence and terms of these terms and of the obligations of confidentiality herein.
    d. Use, and require its employees to use, at least the same degree of care to protect Information as is used with consultant's and/or vendor's own proprietary and confidential information.
5. Information furnished in written, pictorial, magnetic and/or other tangible form shall not be duplicated by consultant and/or vendor except for purposes of this Agreement or as required by law.
6. To indemnify and hold harmless HCSC in connection with any claim based upon the disclosure by HCSC of any information and/or documentation regarding any person to consultant and/or vendor or breach by consultant and/or vendor of any obligation under this Agreement.

7. Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.
8. Consultant and/or vendor shall execute HCSC's Confidential Data Release and Indemnification Agreement.
9. Employer shall designate consultant and/or vendor on the appropriate Business Associate documentation.

V. COMPENSATION

Employer agrees to pay HCSC fees as described in Exhibit A for services performed by HCSC under this Agreement.

VI. AUDITS

Employer shall, at Employer's sole expense, audit data submitted in connection with the RDS prior to submission of the final reconciliation. HCSC agrees to cooperate with and make records available to Employer and/or Employer's auditor. Employer shall retain responsibility for making any necessary corrections or disclosures to CMS.

VII. ACKNOWLEDGEMENT OF PURPOSE OF DATA

Pursuant to 42 C.F.R. §423.884(c)(3)(iii), HCSC acknowledges that information it provides to Employer pursuant to this Agreement may be used by Employer for the purpose of obtaining federal funds.

VIII. APPEALS

In the event that CMS makes an adverse initial determination with respect to Employer's RDS eligibility, subsidy application, attestation of actuarial equivalence, RDS payment, or other similar determination, HCSC shall not be responsible for any procedural or substantive activities associated with Employer's appeal rights described in 42 C.F.R. §423.890. HCSC will provide Employer with reasonable access to information that Employer may need to exercise its appeal rights, but Employer shall be solely responsible for submitting any request for reconsideration, request for informal hearing, request for review by the CMS Administrator, or request for reopening in accordance with such appeal rights.

IX. LIMITATION OF LIABILITY

HCSC shall not be liable to Employer for any RDS amounts that are not paid by CMS, or that CMS recoups for any reason. Under no circumstances shall HCSC be liable for any loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to this Agreement.

X. STANDARD OF CARE, COOPERATION AND REGULATORY CHANGES

A. Standard of Care. The parties recognize that because the RDS program is new, the RDS Requirements and procedures are not fully defined and developed, and that subsequent administrative guidance or requirements from CMS may materially alter the scope of services or manner in which the services contemplated by this Agreement are to be provided. In light of these factors, HCSC will make a good faith effort to compile and provide complete and accurate information in accordance with its best understanding and interpretation of the RDS Requirements.

1. Data Obtained from Third Parties. In satisfying its obiligations under this Agreement, HCSC may utilize and/or obtain and/or provide data that is developed and maintained by third parties with which it contracts, including, but not limited to, Prime Therapeutics, LLC or other similar entities (collectively referred to as "HCSC third parties"). By obtaining this data from a third party source, HCSC does not warrant and/or assume responsibility for the accuracy of such data for purposes of the RDS. In addition, HCSC may obtain or use data or information provided by Employer or third parties not contracted by HCSC. HCSC does not warrant and/or assume responsibility for the accuracy of any data provided by Employer or any third party not contracted by HCSC.

2. HCSC Data. The parties recognize that HCSC's existing data sources, and those of its subcontractors, were not designed for purposes of the RDS. Thus, HCSC cannot and does not guarantee the accuracy of such information and data for purposes of the RDS.

B. Cooperation. The parties recognize that they must mutually cooperate to perform the services required under this Agreement, and that HCSC is not responsible if it is unable to complete any tasks because Employer, or any third party contracted or designated by Employer, fails to meet its obligations, including providing required data.

C. Regulatory Changes. If either party believes that subsequent guidance or requirements from CMS has materially altered the scope of services or manner in which the services contemplated by this Agreement are to be provided, or that any provision of this Agreement is inconsistent with RDS Requirements, that party shall promptly notify the other party in writing, and the parties shall negotiate in good faith to amend this Agreement.

XI. RETENTION OF RECORDS

HCSC and Employer shall maintain all records required by 42 C.F.R. §423.888(d)(3) for a period not less than ten (10) years after the expiration of the Qualified Retiree Prescription Drug Plan year in which Part D Drug costs were incurred, or as otherwise required by law.

XII. HIPAA COMPLIANCE

The parties acknowledge and agree that this Agreement involves the use and disclosure of data that may include HIPAA protected health information. The parties therefore agree that all uses and disclosures of HIPAA protected health information pursuant to this Agreement, including any transition services developed under Section III., will be undertaken in compliance with HIPAA and all regulations adopted in connection therewith. Further, the parties agree that the activities under this Agreement will be subject to the Business Associate agreement between the parties. Specifically, Employer warrants and represents that the intended use of such information is for the Employer's participation in the RDS program and related plan adminstrative purposes and that the information will not be used for employment-related actions and decisions. The parties agree to make any necessary amendments to written documents in effect related to the Employer's qualified prescription drug plan prior to the Effective Date of this Agreement to assure HIPAA compliance for the RDS-related services under this Agreement.

HCSC shall provide minimum necessary HIPAA protected health information directly to Employer or Employer's designee under Section IV. and pursuant to the terms of the HIPAA business associate agreement between HCSC and Employer.

XIII. MISCELLANEOUS PROVISIONS

A. Amendments. All amendments to this Agreement must be agreed to in writing by the authorized representative of each party.

B. Assignments. This Agreement may not be assigned by either party to an unrelated third party without the prior written consent of the other party.

C. Subcontracting and Performance. The parties acknowledge and agree that HCSC may use subcontractors to perform some or all of the services described in Section IV. Further, any of the services to be performed by HCSC under this Agreement may be performed by HCSC, or any of its subsidiaries (including any successor corporation, whether by merger, consolidation, or reorganization), without prior written approval by the Employer. Any reference in this Agreement to HCSC shall include its directors, officers and employees as well as the directors, officers and employees of any of its subsidiaries and HCSC shall be responsible and liable for all performance or failure to peform by such subsidiaries in connection with this Agreement.

D. Entire Agreement. This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement will be valid or binding.

E. Governing Law. This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of Texas without regard to any state choice-of-law statutes, and any applicable federal law. All disputes arising out of this Agreement will be resolved in Texas.

F. No Third Party Beneficiaries. Nothing in this Agreement is intended to create, or will be deemed or construed to create, any rights or remedies in any third party including, without limitation, Employer's active and retired employees (and their dependents).

G. Notice and Satisfaction. The parties agree to give one another written notice (pursuant to Section H., Notices, below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the other party thirty (30) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to the concern or complaint.

H. Notices. Any notice required or desired to be given relating to this Agreement will be in writing and will be either hand delivered, or sent by U.S. mail, postage prepaid and return-receipt requested (receipt will be deemed to be five (5) days after postmark by the U.S. Postal Service), or overnight courier addressed as follows:

HCSC: Blue Cross and Blue Shield of Texas
901 South Central Expressway
Richardson, Texas 75080
Attention: Ted Holden

With a copy to General Counsel at the same address

City of Houston: City of Houston Human Resources Dept.
611 Walker, 4th Floor
Houston, Texas 77002
Attention: Lonnie Vara, Human Resources Director

Notices given hereunder will be deemed given upon documented receipt. The addresses to which notices are to be sent may be changed by written notice given in accordance with this section.

I. Severability. If any provision of this Agreement is rendered invalid or unenforceable by any local, state, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement will remain in full force and effect.

J. Status as Independent Entities. Nothing in this Agreement is intended to create, or will be deemed or construed to create, any relationship between HCSC and Employer other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither HCSC nor Employer, nor any of their respective agents, employees, subcontracteors or representatives will be construed to be the agent, employee, subcontractor or representative of the other.

K. Exhibits. Each Exhibit to this Agreement is made a part of this Agreement as though set forth fully herein. Unless otherwise specifically set forth in an Exhibit, any provision of this Agreement that is in conflict with any provision set forth in an Exhbit will take precedence and supersede the conflicting provision of the Exhibit with respect to the subject matter covered by that provision of this Agreement.

L. Force Majeure. Neither HCSC nor Employer will be liable for its failure to perform any obligation under this Agreement because of contingencies beyond its reasonable control, including but not limited to strikes (other than strikes within such party's own labor force), riots, war, fire, acts of God, disruption or failure of electronic or mechanical equipment or communication lines, telephone or other interconnections, unauthorized access, theft, or acts in compliance with any law or government regulation. If a party's failure to perform continues for more than twenty (20) business days, the other party will have the right to terminate this Agreement immediately.

M. Headings. The headings in this Agreement have been included solely for reference and are to have no force or effect in interpreting its provisions.

N. Counterparts. This Agreement may be executed in counterparts, any of which need not contain the signature of more than one party, but all of which taken together, will be one and the same agreement.

O. Survival. The provisions of this Agreement regarding Term and Termination, Audits, Indemnificiation, Limitation of Liability, Retention of Records, HIPAA Compliance and Miscellaneous provisions will survive the expiration or termination of the Agreement for any reason.

IN WITNESS WHEREOF, the parties have executed this Agreement.

ATTEST/SEAL.

BLUE CROSS AND BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY

By: _____
Name: JEAN A. PERKINS
Title: ASST SECY.

By: _____
Martin G. Foster, President

ATTEST/SEAL:

_____
City Secretary

CITY OF HOUSTON, TEXAS
Signed by:

_____
Mayor

APPROVED:

_____
Human Resources Director

COUNTERSIGNED BY:

_____
City Controller

APPROVED AS TO FORM:

_____
Sr. Assistant City Attorney
L.D. File No.

DATE COUNTERSIGNED:

3-21-06

EXHIBIT A

ADMINISTRATIVE FEES

The following services and reports will be provided at no charge:

- The periodic drug costs, rebate data and other reports and any corrections to those reports, as specified in Section IV.B. ("Data Required for RDS Payments") and Section IV.C. ("Corrections and Modifications") of this Agreement
- Records access pursuant to Section VI. ("Audits") and Section VIII. ("Appeals")
- Transition Services pursuant to Section III.C. ("Transition Requirements") of this Agreement.

EXHIBIT O - RECOVERY LITIGATION AUTHORIZATION

The Plan Sponsor hereby acknowledges and agrees that the Administrator may, at its election, pursue claims of the Plan Sponsor and/or the Plan, which are related to claims that the Administrator pursues on its own behalf, subject to the following terms and conditions:

(1) The Administrator shall have the right to select and retain legal counsel.

(2) Any lawsuit filed or arbitration initiated by the Administrator will be done in the name of the Administrator for its own benefit, as well on behalf of the Plan Sponsor and possibly other parties. The Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Plan Sponsor and/or the Plan without the Plan Sponsor's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Plan Sponsor and/or the Plan with attorneys identified as counsel for the Plan Sponsor or in the name of two or more parties, including the Plan Sponsor and the Administrator, with attorneys identified as counsel for the Plan Sponsor, the Administrator and possibly other parties.

(3) The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including, providing appropriate authority to communicate with the Plan Sponsor concerning issues pertaining to any class actions and pursuant to which the Plan Sponsor specifically declines representation by class litigation counsel.

(4) The Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

(5) The Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.

(6) Any and all recoveries, net of all investigative and other expenses relating to the recovery, including costs of settlement, mediation, arbitration or litigation including attorney's fees, made through any means pursuant to the provisions of this Exhibit, including, but not limited to, settlement, mediation, arbitration or trial, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by the Administrator on any reasonable basis it deems appropriate.

(7) Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. The Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. The Plan Sponsor shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of the Administrator.

(8) The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

(9) Nothing in the provisions of this Exhibit shall require the Administrator to assert any claims on behalf of the Plan Sponsor and/or the Plan.

(10) Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation,

mediation, arbitration or settlement negotiation; therefore, the Plan Sponsor acknowledges that the efforts of the Administrator may not result in recovery or in full recovery in any particular case.

(11) The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require the Administrator to assert any claims on the Plan Sponsor's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after the Administrator has asserted a claim on behalf of the Plan Sponsor and/or the Plan but before any recovery, the Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

(12) If the Plan Sponsor should desire to participate in a class or multi–district settlement rather than defer to the Administrator, the Plan Sponsor may reverse the exercise of discretion authorized herein by affirmatively opting into a class settlement and by notifying the Administrator of its decision in writing, immediately upon making such determination as provided for under Section 10.15. of the Agreement.

(13) The Plan Sponsor further acknowledges and agrees that, unless it notifies the Administrator to the contrary in writing as provided for under Section 10.15 of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Administrator, on behalf of the Plan Sponsor and/or the Plan, to:

a. Pursue claims that the Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;

b. Opt out of any class action settlement or keep the Plan Sponsor and/or the Plan in the class, if the Administrator believes it is in the best interest of the parties to do so;

c. Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.

The Plan Sponsor further acknowledges and agrees that the Administrator's decision to pursue recovery in connection with particular claims shall be in the Administrator's sole discretion and the Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of the Plan Sponsor and/or the Plan when, as, and if the Administrator determines that such claims may be pursued in the common interest of the parties.

The parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail.

EXHIBIT P

Health Risk Assessment Incentive. BCBSTX will provide a fifty dollar ($50.00) gift card to each Subscriber (but not Dependents) who completes a Health Risk Assessment (HRA) in the calendar year 2006 through BlueAccess for Members online at www.bcbstx.com This gift card will be paid only if the Subscriber authorizes the results of the HRA to be shared with the BCBSTX medical management staff, which authorization is given through the HRA completion process. Administrator shall offer this same one time incentive to new Subscribers hired during the second and third contract years and the first and second optional contract years.

BLUE CROSS AND BLUE SHIELD
REQUIRED NOTICES AND DISCLOSURES

CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

1. **Claim Administrator's Separate Financial Arrangements Regarding Prescription Drugs**

   a. **Claim Administrator's Separate Financial Arrangements with Participating Prescription Drug Providers**

   All amounts payable to the Claim Administrator by the Employer for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required Coshare, deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and the Claim Administrator, whichever is less.

   The Claim Administrator hereby informs the Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement.

   The Employer understands that the Claim Administrator may receive such discounts during the term of the Agreement. Neither the Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

   b. **Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers**

   The Claim Administrator hereby informs the Employer and all Covered Persons that it owns a significant portion of the equity of Prime Therapeutics LLC and that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with the Claim Administrator.

   Based upon previous experience with such rebates, the Claim Administrator has estimated that any drug rebate for the Employer would

with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or

(3) An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non–Claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Covered Person and the Employer from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over– or underestimation of past prices. However, the amount paid by the Covered Person and the Employer is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Employer being held in a variance account by the Host Blue, pending settlement with its participating Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Employer and are eventually exhausted by Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either a) to use a basis for calculating a Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or b) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Claim Administrator would then calculate the Covered Person's liability and the Employer's liability for any Covered Services consistent with the applicable state statute in effect at the time the Covered Person received those services.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti–fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a Claim–by–Claim or prospective basis.

BlueCard Fees and Compensation

The Employer understands and agrees a) to pay certain fees and compensation to the Claim Administrator which the Claim Administrator is obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to the BlueCard vendors and b) that fees and compensation under BlueCard may be revised from time to time without the Employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a Claim is processed through BlueCard and include, but are

event the Employer shall reimburse the Claim Administrator the amount paid by the Claim Administrator to the Servicing Plan for Claim Payments plus any service charges payable by the Claim Administrator to the Servicing Plan, in addition to applicable service charges of the Claim Administrator hereunder.

The Claim Administrator hereby informs the Employer, and the Employer acknowledges, that the Claim Administrator's, the Host Plans' and the Servicing Plans' Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing software used to process Claims for services rendered by the Claim Administrator's Providers, Host Plans' Providers and the Servicing Plans' Providers may result in minor deviations in Claim processing and/or pricing of Claims for same services.

ADDENDUM B
TRANSFER PAYMENT AND
OTHER FINANCIAL RESPONSIBILITIES

The Transfer Payment and Other Financial Responsibilities described herein shall apply to the Preferred Provider Organization (PPO) Administrative Agreement ("the Agreement") between BCBSTX (Administrator) and the City of Houston (Plan Sponsor) to which this Addendum B is attached beginning with the Effective Date as shown in Section 3.1 of Agreement and shall remain in full force and effect according to the terms of the Agreement unless amended or replaced by the parties to this Agreement in writing.

All provisions of the Agreement, its addenda, exhibits, and amendments shall apply to this Addendum B, including any definitions.

SECTION I
DEFINITIONS AS USED IN THIS ADDENDUM B:

1.01 **Bank** means a banking entity organized and existing under the laws of the United States, whose address and account number are provided on each request for Transfer Payment and each claim settlement.

1.02 **Net Claims Paid** means the net benefit payment calculated by the Administrator, upon submission of a Claim, in accordance with the benefits specified in the health benefit plan, plus any supplemental charges.

1.03 **Transfer Payment** means a payment (in the amount outlined in Section 2, below), via wire transfer, by the Plan Sponsor to Administrator's Bank.

1.04 **Transfer Payment Period** means a seven day period, beginning Saturday and ending the following Friday.

SECTION II
NET CLAIMS TRANSFER PAYMENT

2.01 In consideration of the Administrator's responsibilities as set forth in the Agreement and at the end of each Transfer Payment Period, the Plan Sponsor shall transfer to the Administrator's Bank an amount equal to the Transfer Payment Period's Net Claims Paid.

2.02 The Transfer Payment Period shall be weekly. The Administrator shall advise the Plan Sponsor by e-mail or facsimile, at an e-mail address or facsimile number to be furnished by the Plan Sponsor prior to the effective date of the Agreement, of the amount of Net Claims Paid pursuant to the Agreement for which reimbursement has not been previously made by the Plan Sponsor to the Administrator, plus the applicable administrative fees.

2.03 If any day on which a Transfer Payment is due is a holiday, such payment will be made on the next business day.

2.04 Transfer payment must be made within 24 hours of notification.

SECTION III
CLAIM SETTLEMENTS

3.01 Health Claims (Medical)

(a) A claim settlement shall be determined for each monthly period. Such period will be referred to as the claim settlement period. The claim settlement shall reflect the sum of the following:

(1) All Net Claims Paid calculated on the basis of claim payments paid by the Administrator in the particular claim settlement period.
(2) All Net Claims Paid calculated on the basis of claim payments paid by the Administrator in prior claim settlement periods that have not been included in a prior claim settlement.
(3) The administrative charges specified in the most current Fee Schedule attached to this Agreement.

The sum of 1, 2, and 3, above, shall be referred to as the claim settlement total.

(b) If, within the claim settlement period, the claim settlement total exceeds the Transfer Payments, the Plan Sponsor will pay the difference to the Administrator. The claim settlement will be determined within thirty days from the last day of the claim settlement period. The Administrator will notify the Plan Sponsor in writing of the results of the claim settlement. Any sums due the Administrator will be paid by the Plan Sponsor in the manner indicated by the most current Fee Schedule, attached to the Agreement. The claim settlement must be paid within ten days from the date the Administrator notifies the Plan Sponsor.

(c) If, within the claim settlement period, the Transfer Payments exceed the claim settlement total, the Administrator may, at its option:

(1) pay such difference to the Plan Sponsor,
(2) apply the difference against amounts then owed the Administrator by the Plan Sponsor or;
(3) authorize a reduction equal to such difference from the next claim settlement due the Administrator from the Plan Sponsor.

3.02 Prescription Drug Program

In the event the Plan Sponsor has purchased a Prescription Drug Program, on a weekly basis, Administrator shall notify the Plan Sponsor of, and the Plan Sponsor shall include in the Transfer Payment, an amount sufficient to reimburse Administrator for Prescription Drug Program benefit checks issued, including "good faith" payments made to BCBSTX participating pharmacies honoring identification cards issued by BCBSTX to the Plan Sponsor's health benefit Plan, as defined in the Agreement.

3.03 Out-of-State Claims

(a) In the event that Fee-for-Service Medical Charges, as defined in the Agreement, are incurred by Participants of the group in states other than Texas, then those other participating Blue Cross and/or Blue Shield plans

will pay most claims directly to their providers. Administrator is required under these arrangements to reimburse such other participating Blue Cross and/or Blue Shield plans daily.

(b) On a weekly basis, Administrator shall notify the Plan Sponsor of, and the Plan Sponsor shall include in the Transfer Payment, the amounts BCBSTX reimbursed such other participating Blue Cross and/or Blue Shield plans.